CORRESPONDENCE

Correspondents are asked to be brief

Streptococcal Sore Throat

SIR,—Your leading article on "Streptococcal Sore Throat" (15 July, p. 132) discussed the utility of swabbing and the efficacy of penicillin in the diagnosis and treatment of sore throat. You conveyed the impression that both procedures are out of date.

The results of swabbing depend, among other factors, upon the choice of swabs.[1] You quoted Ross[2 3] who showed that it was easier to isolate *Streptococcus pyogenes* from saliva collected by pipette than from salivary swabs from the sublingual pool or from throat swabs. Ross used proprietary (Exogen) swabs of buffered absorbent wool sterilized by ethylene oxide; he quoted his own unpublished M.D. thesis as evidence that such swabs maintained *Str. pyogenes* in a viable state. Our published[4] assessment of buffered absorbent wool swabs, albeit charcoal-coated and steam-sterilized, showed that they were only slightly less lethal to *Str. pyogenes* than untreated wool swabs. It seems unlikely that Exogen swabs would be any better. Ross's demonstration that salivary swabs yielded fewer *Str. pyogenes* than pipetted saliva suggests that his swabs may well have been bactericidal and that his throat swabs results may therefore have been invalid.

As regards treatment it was shown by Wannamaker *et al.*[5] that penicillin would not eradicate *Str. pyogenes* unless given in a dose of at least 500,000 units twice daily for 10 days. Brumfitt and Slater,[6] whom you cited, confirmed that smaller doses of penicillin spread over a shorter time failed to eradicate *Str. pyogenes* although they caused a significant reduction in the duration of symptoms.

It is certain, as you said, that "the last word has yet to be written on the utility of swabbing sore throats and giving the patients penicillin" but words written about evidence gathered by using bactericidal swabs and inadequate amounts of penicillin do not get us much nearer to the truth. In these respects it must be agreed wholeheartedly that, in your words, "doctors should critically examine their traditional approach to this common affliction." This critical examination might start by re-reading the papers of Rubbo and Benjamin[1] and Wannamaker *et al.*[5] which have been so sadly disregarded for 21 and 19 years respectively. How many doctors are still using bactericidal swabs and five-day penicillin courses for the diagnosis and treatment of sore throats? Both procedures are valueless when thus misapplied, which is not to say that diagnostic swabbing and penicillin treatment are not useful when properly employed.

A very recent example occurred when a doctor in medical charge of a girls' school had 20 or so cases of streptococcal tonsillitis within a short period. He collected nose and throat swabs (albumin-coated) from 206 people in the school which revealed six nasal and 18 throat carriers. The nasal carriers were treated with penicillin in isolation while the throat carriers were treated in the school; in all cases treatment was continued for 10 days and all the carriers were cleared. No further clinical cases of sore throat occurred in the school, threatened cancellation of the swimming sports proved unnecessary, and the headmistress sent me a charming letter of thanks for the assistance given to her efficient school doctor. Both swabbing and penicillin were extremely useful in this incident. The same doctor and I had learned our lesson the hard way four years earlier when we failed promptly to control a streptococcal outbreak in another school because I issued bactericidal swabs and he gave too little penicillin.—I am, etc.,

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1 Rubbo, S. D., and Benjamin, M., *British Medical Journal*, 1951, **1**, 983.
2 Ross, P. W., *Journal of Hygiene*, 1971, **69**, 347.
3 Ross, P. W., *Journal of Hygiene*, 1971, **69**, 355.
4 Bartlett, D. I., and Hughes. M. H., *British Medical Journal*, 1969, **3**, 450.
5 Wannamaker, L. W., *et al. New England Journal of Medicine*, 1953, **249**, 1.
6 Brumfitt, W., and Slater, J. D. H., *Lancet*, 1957, **1**, 8.

Legal Abortion

SIR,—After reading Mr. A. Howard John and Mr. Brian Hackerman (8 July, p. 99) on the effects of abortion on their gynaecological service I should like to offer the following comments.

The aim of the Abortion Act was to reduce the number of unwanted pregnancies and so a profound effect on the birth rate was not to be expected.

The main expectation was that the number of criminal abortions would decrease. Since there are no statistics for these cases we know neither the size of the problem nor its class distribution. It seems likely that most abortionists were (and are) fairly competent, otherwise their careers would not have been long lived. It seems equally likely that most criminal abortions seen in hospital are self-inflicted by women who, for various complex reasons, preferred not to involve anyone in their problem. Such patients must still exist and perhaps benefit could be gained by investigating their motives.

To imply that there has been a rise in the number of criminal abortions because the number of emergency evacuations has remained constant seems hasty. How many of these cases are recurrent or habitual abortees, how many have had previous theraputic abortion in "another place," and how many represent those high risk pregnancies booked into the authors' obstetric unit who subsequently miscarry?

To me the illegitimacy rate signifies the presence of a large number of women who want a child without the inconvenience of a husband. This trend was forseeable, and underestimated, with a softening of society's attitude towards the *feme-sole* and a greater acceptance of sexual emancipation. The rise of the illegitimacy rate may become totally irrelevant in future discussions of contraception and abortion policy because of this change in attitude.

Beyond these points there is an obvious problem of strained gynaecological services. As the authors' suggested, day abortion clinics would considerably ease the strain.