CORRESPONDENCE

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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 You conveyed the impression that both procedures are out of date.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 Ross used proprietary (Exogen) swabs of buffered absorbent wool sterilized by ethylene oxide; he quoted his own unpublished M.D. thesis as evidence that such swabs maintained *Str.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 published⁴ 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 ex-

amine their traditional approach to this common affliction." This critical examination might start by re-reading the papers of Rubbo and Benjamin¹ 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 therapeutic 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 foreseeable, 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.

I do not share their pessimism with regard to staffing since I feel that a multi-disciplinary approach to sexual matters will appeal to a new generation of doctors, particularly if abortion services were part and parcel of a unified family planning service with the problems of contraception, sterilization, and sexual difficulties well represented.

The problems are complex but since there is public demand, it is our duty to give carefully thought-out advice. If a new specialty is needed should the medical profession demur; has there ever been a time that a new challenge has been ignored successfully?—I am, etc.,

J. D. WILLIAMSON

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Sex and the Single Girl

SIR,—Dr. J. Campbell Murdoch (22 July, p. 235) is right to criticize Drs. C. McCance and D. J. Hall (17 June, p. 694) for saying that a contraceptive service should be "morally uncommitted," but he is right for the wrong reason. He is right to say that a doctor who leaves his standards behind him becomes a danger to himself and to others, but he is wrong to imply that moral standards and a sense of commitment are the prerogative of those who believe in God.

Surely, a doctor has both moral standards and a sense of commitment if his words and actions are based on his own beliefs in what is in the best interests of his patient. The doctor, however, must be aware of the consequences of his action: what is the effect upon the patient? Is the patient filled with a sense of beatification comparable to that in the doctor at the end of his homily?

According to our age/sex register, there are over 4,000 girls in their twenties and thirties in our group practice: the area consists largely of large houses divided up into flats. It is our experience that the alternative to contraception is not continence but pregnancy. If a girl is advised against contraception she might go to another doctor or to the F.P.A. or she might risk pregnancy by using the "safe" period or coitus interruptus. If the girl intended to be continent then it is unlikely that she would have asked for contraception in the first place, and, furthermore, our experience would corroborate the findings from Aberdeen that many girls seek contraception after first intercourse.

Thus, advice against contraception is given too late and if heeded will cause guilt (which is the most damaging and far-reaching of all iatrogenic diseases) on the one hand or pregnancy on the other.—We are, etc.,

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A Virus from Epidemic Vomiting Disease

SIR,—The authors of this excellent paper (8 July, p. 86) rightly state that the commonest abdominal symptom is a feeling of distension. May I add that x-rays of the abdomen taken at this stage show considerable gaseous distension confined to the transverse colon in the supine position. The gas would shift by its buoyancy into the ascending or descending colon in left or right

recumbency. Unlike gastroenteritis caused by other pathogens, fluid levels in the colon are absent or insignificant. There is probably a causal relationship between the two phenomena, the excess gas in the transverse colon being responsible for the feeling of epigastric distension.

In hospital practice these cases are often referred to the x-ray department under the clinical suspicion of appendicitis in children or of pancreatitis in adults. The picture is sufficiently characteristic for the radiologist to suggest that epidemic vomiting disease might be taken into consideration in the differential diagnosis (Fig.).—I am, etc.,

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¹ Hajdu, N., *Réunion Internationale de Radiologie Pédiatrique*, 1963, Abstract 37.

Women Returning to Medicine

SIR,—No doubt many readers will have read with interest the article in *The Times* "Women's Role in Medicine" (14 June) giving an account of the existing part-time, postgraduate training arrangements custom-built to fit each woman's needs. We refer to Dr. Rosemary Rue's scheme in Oxford and Dr. Michael Essex-Lopestri's scheme in the South-west Metropolitan Region.

Now that Sir Keith Joseph has announced his women doctor's retainer scheme (17 June, p. 723), many women may feel a strong urge to take advantage of it, but are fearful to embark least they are unable to cope in the event of some domestic crisis. Crèches, play groups, and other such services are valueless when your child falls ill.

In Leeds we now have the answer to this problem in the form of the Family Emergency Association. This organization, which has been running successfully since 1969, is a mutual members club, and is legally recognized by the Town Clerk. (A mutual members club has two kinds of members—mutual members and donor members. The former are those who anticipate a need for help, though they can, if they wish, also provide help at other times; the latter provide help requested. We have not yet failed any member who required a "substitute mum" in an emergency. We feel that there must be many women medical graduates in Leeds who would gladly take advantage of these very good retraining schemes if they also had an insurance against the event of a domestic crisis.

It is for this reason that we wish to draw their attention to the existence of this service, and prevent them from letting splendid opportunities for retraining pass them by.—We are, etc.,

E. A. COLVILLE
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Platelet Adhesion and Aggregation

SIR,—Your leading articles must be factually correct, but when talking about platelet embolism and platelet aggregation and adhesion to glass you state that "these two properties appear to be identical" (8 July, p. 67). Most workers in the field would insist that you are wrong. It is true that in Glanzmann's thrombasthenia both platelet aggregation and adhesion to glass are abnormal. However, it is also generally accepted that in von Willebrand's disease platelet retention in a glass bead column is markedly decreased, and this test certainly involves platelet adhesion to glass. Platelet aggregation however is strictly normal. Contrary, immediately after two major operations, for example, platelet aggregation relative to the preoperative level is decreased but retention in the glass bead column is increased.¹ Thus these tests can vary independently, and this must mean that although perhaps some properties are shared, nevertheless some quite different mechanisms must operate. This at least is established even if full details of these two processes are still unknown.—I am, etc.,

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¹ O'Brien, J. R., Etherington, M., Jamieson, S., and Klaber, M. R. *Lancet*, 1972, 1, 1302.

Cytology in General Practice

SIR,—Dr. B. Scaife and his colleagues (22 July, p. 200) describe a model for screening a busy industrial practice for precancerous conditions of the cervix. They are to be congratulated in reaching almost 90% of patients considered to be at risk.

May I comment on English "resistance" to cytology tests? Recently, as part of a research project, I visited a large industrial firm in Birmingham in an attempt to find out why a repeat screening by cytology produced almost the same percentage of acceptance (less than 20%). With my colleagues A. J. Lucas, general practitioner, and Margaret Attwood, head of the Ministry cytology school in this department, I attended a meeting arranged by the medical officer in charge of the health of an industrial complex with some 8,000 women employees. Women shop stewards discussed with us the reasons why employees continued to decline cytostests. Their reasons correspond to those given by Dr. Scaife and his colleagues, namely that (pregnancy apart) English women suffer from a kind of shyness when the organs of reproduction are mentioned. The women shop stewards made the original suggestion that we should approach all husbands by letter, explaining the value of preventing cancer of the neck of the womb so that they might encourage their wives to take a "prevention test."

In the factory there were many women