It would be well to remind those faced with this difficult therapeutic problem that the only proved portal of entry of candida following cardiac surgery is the infected intravenous drip site, through which antibacterial antibiotics are often being administered, thus providing a further selective pressure.[7] An essential part of the management is the removal and if necessary replacement of these infected intravenous lines, though this alone cannot be relied upon to be curative. Perhaps it is wise to reconsider the twice-weekly flushing of long-standing infusions with dilute solutions of amphotericin, as suggested by Brennan and his colleagues.[8]—I am, etc.,

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G.M.C. and Indian Qualifications

SIR,—There has recently been considerable correspondence on the low professional standards of Indian doctors and on excessive emigration from developing countries (7 June, p. 562, 5 July, p. 43, and 26 July, p. 229) and I hope that yet another individual's mode of solution warrants expression. Rather than emphasize reduced morale, I prefer to pay attention to the frustrations that produce this; and in India, where I have been as a visiting lecturer, this seems occasioned mainly by lack of teachers to produce the calibre for negotiating their need.

The massive problem of raising the health level and the college teaching level of a whole subcontinent, whose health directors are aware of this need, is probably best understood by those who have travelled beyond the major city centres there and who have thought proportionately about the number of hospitals and teaching centres of the top grade relative to the size of the country and the population. The major centres in Calcutta, Madras, Delhi, and Bombay and the two Christian colleges of Vellore and Ludhiana display enormous influence, yet compared with ourselves they still experience daunting hardships to overcome their environmental, social, and sickness problem. The rate of development of more than 130 other colleges is the initiative of the Indian government, plus one founded by the charity of the Indian Roman Catholic Church. Because of the struggle to reach higher standards, and to learn, a large number of postgraduates seek posts in the U.K. This is an expensive tide in the wrong direction and is occasioned by a migration to find teachers.

For three years I have personally taken package two-week haematology postgraduate lectures and practicals, of 20 sessions in all, to three lesser colleges in India (having made contacts at a preceding visit). In a five-week stay I have given these courses twice (two share a course), and in the remaining week I have supplied selected specialist lectures to a variety of disciplines, institutes, and societies.

This system turns the tide of need and joins with college level in India, which is where medical standards are set and from which graduates disseminate. One specialist, and one fare, encompass the practical requirement of two centres there and the entire postgraduate complement of the locality having an interest in that specialty. A two-week course is a standard generous format for Britain. Its preparation by one person to suit their need has been a stimulus to morale and comprehensive knowledge also for myself, which is not lost in the stereotyped format of our own Health Service.

In such a scheme the only answer to the economic lag of developing countries is to stand the expenses from the affluent end. Over the three-year sequence and the preparatory year 12 weeks have been granted as leave of absence with pay by the regional hospital board (and its successor, the area health board, which has been more stringent). I paid the fare and the receiving institutions mostly supplied full board at their cost. The remaining weeks in each course were classed as holiday.

The clause available to consultants for negotiation in Scotland is No. 252(*b*) of Terms and Conditions of Service for Hospital Medical and Dental Staff (Scotland). It is a matter of opinion how much concern should be shown for the privilege gap and for experts how to resolve the major finance issues. For the ordinary person who is interested we have to pull in our belts individually and think of return for money nationally. This system does both of these. A need is met on its own ground and those Indians who still want to come to U.K. become of better calibre. It is still, however, a major exercise to decipher at which institutes in India supplementation is wanted and to elicit long-term development schemes which could be supported in this way over many years.—I am, etc.,

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Oral Contraceptives in Women Over 34

SIR,—The recent reports by Dr. J. I. Mann and others (3 May, p. 241) and by Drs. J. I. Mann and W. H. W. Inman (p. 245) confirming the association between the risk of myocardial infarction and taking combined oral contraceptive pills must cause prescribers to review their current practices. This work follows that of others.[1-3] It seems important that in women aged over 34 years with various predisposing risk factors, such as diabetes, obesity, heavy smoking, hypertension, and type II hyperlipidaemia, an alternative method of contraception should be recommended, as the effect of the combined oestrogen-progestogen pill is synergistic.

It may be argued that the risk of mortality or morbidity from pregnancy for such women if they use alternative methods far outweighs even the synergistic enhancement of risk from the combined pills. The confidential inquiry for 1967-9[4] suggests that the mortality at 40 years of age is about 800 per million total pregnancies. The inherent fecundity at this age is probably reduced by at least one-third from that of women of 25, so a less apparently effective method of contraception such as a barrier or intrauterine device may give enough protection to reduce the mortality risk below that from taking the pill. An ideal solution would be to use a less effective method with early abortion in case of failure, provided the woman would find this policy acceptable. Alternatively sterilization might be best. Vasectomy under local anaesthesia, which carries virtually no mortality risk, seems to offer a good alternative.

The problem may be numerically small. In the King's College Hospital clinic out of 6534 registrations only 103 (1·6%) were pill acceptors over 34 at their first visit. These were only 4·2% of all pill acceptors. General practitioners may well be seeing more. In Kay's study[3] 19% of pill acceptors were aged over 34. Unfortunately we have kept no routine records on smoking rates but many of the women were 70 kg or more in body weight. Other predisposing factors to acute myocardial infarction were rare. I should be very interested in the experiences of other prescribers and their views on future policy in the light of this evidence.—I am, etc.,

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Clindamycin-associated Pseudomembranous Colitis

SIR,—We wish to report our recent experiences of two cases of clindamycin-associated pseudomembranous colitis. We feel that both cases emphasize important points in the management of this condition.

Both patients presented with sudden onset of profuse watery diarrhoea following an oral course of clindamycin. On admission, both were dehydrated, hypotensive, and prostrated. They had severe, cramp-like abdominal pain with generalized tenderness and distension of the abdomen. The bowel sounds were present but infrequent. There was associated leucocytosis in excess of $20 \times 10^9/l$ ($20\,000/mm^3$). Abdominal radiographs in both patients showed dilated colon with thickening of its walls. Sigmoidoscopic findings in both cases were typical, with creamy-yellow, raised plaques surrounded by hyperaemic inflamed mucosa.

Both patients were submitted to laparotomy because the clinical picture was that of an acute abdomen with profound shock and toxaemia. However, in both cases, straw-coloured ascites was found together with distended, boggy oedematous colon throughout its whole length. There did not appear to be lymph node enlargement. In the first case the abdomen was closed without any further surgical procedure. The patient subsequently had a protracted illness with severe diarrhoea, hypoproteinaemia, albuminuria, massive peripheral oedema, pleural effusions, and anaemia due to acute folic acid deficiency. After six weeks of supportive treatment and systemic steroids the patient started to improve and was discharged well. The second patient underwent total colectomy because of the profound toxaemia associated with dilated colon and pseudopolyposis on abdominal radiographs. This patient died shortly after operation from an acute myocardial infarction.

These two cases demonstrate the clinical problem of whether to operate on patients