cases of acute urinary infection presenting in general practice. The percentages of coliform-proteus organisms, treated as a group, resistant to five drugs over the four years are detailed below to the nearest 0.5%.

Year	Sulphonamide Resistant	Tetracycline Resistant	Nitrofurantoin Resistant	Ampicillin Resistant	Nalidixic Acid Resistant
1967	61.5%	33.5%	3.5%	5.5%	2%
1966	42%	30.5%	5.5%	4%	1.5%
1965	27%	26.5%	8%	3%	—
1964	18%	42%	2%	—	—

It will be noticed that 61.5% of such organisms are now resistant to sulphonamides. The rise since 1964 has been truly dramatic. The percentage of tetracycline resistant strains has remained remarkably steady at about 33%, varying mainly with the proportion of *Proteus* spp. in the sample, as about 90% of such are resistant. Nitrofurantoin, ampicillin, and nalidixic acid all show remarkably low percentages of resistant organisms with much less variation over the years studied.

Finally, it seems rather hard of your contributor to refer to nalidixic acid as "a promising new drug whose range of usefulness is being investigated." It has been available for about five years and I understand about 150 papers have been published referring to it.—I am, etc.,

M. H. ROBERTSON.

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Epping, Essex.

REFERENCE

- ¹ Robertson, M. H., *Brit. J. clin. Pract.*, 1968, 22, 63.

SIR,—I was interested to read Dr. David Brooks's comments (21 September, p. 745) on your article on the management of urinary tract infection (7 September, p. 600). I wonder how many doctors do in fact rely completely on sensitivity tests, especially to sulphonamides; and is the disc test the best? Clinically, there is no doubt that sulphonamides are effective in the majority of cases of urinary infection, and I am sure most practitioners will agree with your expert with his advice that they are the first line of attack.

In patients with acute symptoms the microscope is a remarkably reliable guide to whether urinary infection is present or if one is dealing with the urethral syndrome. But I doubt whether Dr. Brooks's criterion for pyuria is accurate enough for trial purposes. Five cells per high power field in urine unspun and using a 1/6 objective lens would give an approximate count of 200 W.B.C./cu.mm., and this is considerably in excess of the more usually accepted baseline of 50 cells in females and 10 in men.² Withholding treatment in cases with acute symptoms and significant microscopical findings misses the opportunity of a trial with sulphonamides for those few days while awaiting bacteriological results. This trial is worth more than a sensitivity test, and the majority of patients will benefit. Using transport medium, it takes several days to get bacteriological results. This method is as accurate as the specimens will permit, but cannot always differentiate between contamination and significant bacteriuria. I have found a 90% accuracy from over 500 paired cultures.

I find it important to take note of how the patient subjectively responds to therapy³ and if she says she is feeling better, and there is a significant drop in the cell count, and a suggested drop in the semiquantitative bacterial count, then I will go on with the same drug even though bacteriologically the urine is not yet absolutely clear. My experience suggests to me this is a correct attitude provided the follow up is thorough. Sensitivity tests are of great use in the follow up, but even then I am sure they do not provide the complete answer. Incidentally, your article recommends that urines should be centrifuged for pus cells. Is this really necessary, or even desirable, as cells may be lost this way?⁴—I am, etc.,

Swanage, Dorset.

S. H. PURSER.

REFERENCES

- ¹ Dunn, P. M., Hine, L. C., and MacGregor, M. E., *Brit. med. J.*, 1964, 1, 1081.
² Stansfeld, J. M., *Arch. Dis. Childh.*, 1962, 37, 257.
³ Pryles, C. V., in *Current Pediatric Therapy*, ed. by S. S. Gellio and B. M. Kagan, 1964, London.
⁴ Gacholt, H., *Brit. med. J.*, 1964, 1, 1547.

"V.D." as a Diagnosis

SIR,—Your leading article on "V.D." as a diagnosis (14 September, p. 630) states that it is important not to treat until a diagnosis has been confirmed. This assertion, as far as gonorrhoea is concerned, calls for some qualification, for it is a matter of opinion.

Some months ago I saw a young wife who was at risk from her husband, recently treated for gonorrhoea acquired extramaritally. She had had negative smears and cultures regularly for three weeks at another clinic. When I saw her she had bilateral gonococcal salpingitis which need never have been allowed to develop.

When a man readily admits extramarital exposure within an acceptable incubation period and develops gonorrhoea after risking infecting his wife, it has been my practice for 15 years to treat and follow up the wife even though no gonococci have been found. I have never done this if the husband has denied extramarital intercourse, nor do I thus treat empirically the recent unmarried contact except in pressing circumstances—for example, a fiancée about to get married. Many a colleague, like Noel Coward's Malay rabbit, will "deplore this foolish habit," but my conscience is clear. Much ill health, psychological trauma, and not a few broken marriages are probably prevented by this simple prophylactic procedure. When all is said and done, thousands of asymptomatic cases are treated incidentally with antibiotics given for other reasons, to say nothing of World Health Organization efforts to stamp out the treponematoses. Nevertheless, I agree that an attempt at diagnosis should always be made.

Other venereologists may go further and treat prophylactically any and every promiscuous girl attending their clinics. We may yet all come to this if V.D. figures continue to rise.—I am, etc.,

ARTHUR S. WIGFIELD.

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SIR,—Your leading article (14 September, p. 630) was presumably addressed to those who claim no special experience of venereal diseases and who lack the diagnostic and

epidemiological facilities available to V.D. clinics. It is unfortunate, therefore, that Dr. F. J. G. Jefferiss (28 September, p. 802) has introduced this debatable question of so-called "epidemiological treatment"—that is, of giving treatment to known contacts of patients with venereal disease before the diagnosis has been confirmed.

I need not enter into the pros and cons of this procedure, but I believe that most venereologists would agree that if it is to be used at all it should be the result of careful consideration in the individual case, when the diagnosis in the consort is known for certain and the facilities for bacteriological assessment, for ensuring follow-up, and for tracing secondary contacts are the best available. In the absence of this knowledge and these facilities "epidemiological treatment" is not to be recommended; it is only too likely to open the way to indiscriminate treatment of all who have taken risks, and this is highly undesirable.

Dr. Jefferiss's hobby-horses are usually good strong runners, but it is a pity that this one had to be mounted on the present occasion. It is likely to confuse those who might have benefited from the advice given in your leader.—I am, etc.,

London W.1.

A. J. KING.

Deep Vein Thrombosis

SIR,—I was recently quoted in your columns by Mr. N. L. Browse and others (21 September, p. 717) as suggesting that the long-term results of venous thrombectomy in the early cases of iliofemoral venous thrombosis were "not very encouraging."

This statement needs clarification. In my experience complete clearance of the iliofemoral segment is achieved in about 62% of cases, and venographic follow-up over three to five years shows that in only 4% of cases is rethrombosis (not necessarily with re-occlusion) likely to occur. When clearance is partial or incomplete early rethrombosis (within 14 days) is commoner, occurring in 32% of instances. The incidence of complete reocclusion as opposed to some rethrombosis of the segment, even with incomplete clearance, is not high. Partial or incomplete clearance and subsequent reocclusion are most often related to delay in venous thrombectomy.—I am, etc.,

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Aberdeen.

G. E. MAVOR.

REFERENCE

- ¹ Mavor, G. E., and Galloway, J. M. D., *Brit. J. Surg.*, 1967, 54, 1019.

Health Visitors

SIR,—The letters from Dr. John D. Kershaw (24 August, p. 497) and Dr. Mary E. Brennan (7 September, p. 618) are important. Distressing conditions arise because many people go to chemists, herbalists, and other places for help rather than to the N.H.S. establishment, and there are problem families and individuals who have had no help at all. Some of the areas where the greatest difficulties exist are those that have few, no, or inexperienced health visitors. Because of this there is very little domiciliary work, and the health visitor has no time to investigate