There is a great saving in nurses' time and temper. Instead of tedious attention to the drip rate and time-consuming alteration of the concentration of synthetic oxytocin in the infusion bottle, all that is required is a light pressure of the syringe plunger once every quarter of an hour. The very simplicity of the method enables the concentration to be increased expeditiously and the optimal strength attained early.

The apparatus is inexpensive and it is rarely necessary to use more than one litre of 5% dextrose. The amount of synthetic oxytocin can readily be varied. The example given above is for the induction of labour before or after amniotomy, but in the case of uterine inertia, exactly the same method can be used with 5 or 10 units in the charging syringe.

The principle that must be followed at all times is that the infusion is titrated against the strength of uterine contractions. It is clear that the significance in terms of concentration of a 2-unit addition to the infusion bottle becomes progressively greater as the level of residual fluid in the bottle diminishes. Provided that the drip rate is kept at approximately 40 drops per minute and the increments are added regularly every 15 minutes this rarely constitutes a problem, but when the level of fluid in the bottle falls below about 300 ml. it is wise to make additions of only 1 unit at a time.

One snag that has been encountered a few times is that the glass airway intake tube may be of too small a bore to take an FG 6 catheter. This is unfortunately not evident until the rubber seal has been removed and the bottle has therefore to be wasted.—We are, etc.,

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Postoperative Leg Vein Thrombosis

SIR,—We congratulate Mr. N. L. Browse and Mr. D. Negus (12 September, p. 615) on their paper which confirms the contention of Doran and White¹ that electrical stimulation of the calf muscles during operation will reduce the incidence of deep vein thrombosis in the stimulated leg.

We have been conducting a parallel investigation using ¹²⁵I-fibrinogen on the same lines as Mr. Browse and Mr. Negus—that is, stimulating one leg only during operation

and using the unstimulated opposite leg as a control. To our surprise we found a greater incidence of thrombosis on the stimulated side.

Total number of patients	41
Number forming thrombi in legs	16
Total number of thrombosed legs	22
Thrombi on unstimulated side only	3
Thrombi on stimulated side only	7
Thrombi on both sides	6
Total number of thrombi on stimulated side	13
Total number of thrombi on unstimulated side	9

We are encouraged to continue this work until we have a more significant total to report. Meanwhile one may be forgiven for wondering whether there is more in this problem than at first meets the eye.—We are, etc.,

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REFERENCE

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Antibiotic Therapy and Gut Flora

SIR,—Dr. H. Gaya and others (12 September, p. 624) report a significantly higher rate of recovery of *Pseudomonas* and *Proteus spp.* from the faeces of patients receiving oral cephalixin compared with those receiving other antibiotics or no chemotherapy. Both *Pseudomonas* and *Proteus* are relatively resistant to the cephalosporins, and it is therefore to be expected that such organisms will be selected in the presence of antibacterial agents which suppress the commensal flora. The importance of these antibiotic-resistant bacteria must, however, be related to their numbers, and in our opinion undue attention should not be paid to their mere appearance in cultures of the faeces. Detailed examination of bowel contents or faeces using sensitive cultural techniques will reveal small numbers (10–100/g.), of organisms such as *Proteus*, *Staphylococcus*, yeasts, and even *Pseudomonas* in a large number of normal individuals not receiving antibiotics. The numbers increase in long-term hospitalized patients including those not actually receiving chemotherapy.¹ These changes in bowel flora may follow ingestion of the resistant species as the authors suggest in a number of cases, but in others is due to progressive selection of minority populations already present. Patients in different hospitals may therefore vary in their degree of colonization with antibiotic-resistant strains dependent upon local environmental conditions (including the state of culinary hygiene) and on the nature of the antibiotic regimen.

In Edinburgh² a large series of patients has been specifically examined for changes in their gut flora during and after chemotherapy. Our conclusion is that while changes can be shown to occur in the quality of the bowel flora in the majority of patients receiving oral antibiotics this is of little clinical importance as the number of antibiotic-resistant organisms is small (less than 10⁵/g.). More marked increases in undesirable resistant species may occur in individual patients who may demonstrate side effects and become a source of contam-

ination to others. The development of this state should be avoided by regulation of therapy and adequate bacteriological monitoring.

More recently cephalosporins, including oral cephalixin, have been administered to children in hospital for both treatment and prophylaxis of infection as part of an antibiotic trial.^{3,4} Monitoring of the environment, the attendants, and the surfaces and faeces of the patients has not revealed any undue change in bowel flora nor the selection of antibiotic-resistant species such as *Proteus* and *Pseudomonas* in numbers greater than 10³–10⁴/g.—We are, etc.,

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Profile Analysis

SIR,—We have read with considerable interest and surprise the leading article (22 August, p. 417) entitled "Profile Analysis." Interest because the subject is intensely topical, treating as it does with the possible benefits which might be achieved by the application to general practice of multiple screening procedures making use of automated laboratory techniques as currently available in hospitals. Our surprise is occasioned mainly by the fact that you appear, by your leading article, to be suggesting that the views put forward by Professor Whitehead in his inaugural lecture open up a new millennium for the general practitioner.

Some time ago one of us submitted to you the manuscript of a paper representing the results of a considerably larger survey of profile screening in general practice than that reported by Professor Whitehead and his colleagues, and which you decided you were unable to publish. This work, while obviously carried out in a hospital laboratory, had the merit of having been conceived and assessed by the general practitioner concerned, and we feel therefore that the views set out in it perhaps reflect better the impact of profile screening on general practice, than those of Professor Whitehead and his—to use your own term—enthusiastic colleagues. In brief, we are of the opinion that while there may be some benefit to the general practitioner from having available to him profile screening facilities, such benefit varies a great deal, depending upon the accuracy of the normal range of values which is accepted and the practical difficulties of the time that has to be spent in the investigation and follow-up of abnormalities suggested by the results of the profile screening tests. There are also problems of prompt communication of results and prompt collection of specimens,