quote Dr. Pickering's words, against the interests of "the Home Office to discharge the obligation, which it shares with all other Government departments, of ensuring that a check is kept on the disbursement of public funds."

Dr. Pickering has never known another part-time medical officer resign for this reason. I can assure him that this is by no means the only reason for which I resigned my appointment; to publicize the others would contravene the Official Secrets Act and implicate many other people. I can also further assure him that I am by no means the only doctor who considers the triennial review to be professionally objectionable.—I am, etc.,

JOHN H. SWAN.

London W.13.

Gut Flora after Cephalixin

SIR,—Dr. H. Gaya and others (12 September, p. 624) demonstrated alteration in bowel flora following cephalixin therapy. Jambon and colleagues previously reported changes in intestinal flora following 2 g. or 4 g. cephalixin daily for five days, but they concluded that the effect of cephalixin was less than with the tetracyclines: no mention was made of pseudomonas. In the trial by Dr. Gaya and colleagues there is a statistically significant difference between the "cephalexin-treated" group and the "no-antibiotic" group, but there is no statistical difference between the "cephalexin-treated" group and the "other-antibiotic" group ($p > 0.05$). Moreover, the doses of the other antibiotics given are not specified. It is interesting to see that the single patient who developed a pseudomonas urinary infection gave a low percentage (38%) excretion (Table 1, Case 11) with a 24-hour urine output of 760 ml. (assuming the urine excretion specified, 1,000 $\mu\text{g./ml.}$ is a mean value over the 24-hour collection). If the low urinary excretion rates are due to diminished absorption of cephalixin, we wonder whether any correlation would have been found between the acquisition or otherwise of *Ps. aeruginosa* or proteus and the percentage 24-hour urinary excretion of cephalixin had this been done on all patients.

It is not valid to judge oral absorption on the percentage of the daily dose excreted unless renal function is normal, and in the cases reported there is evidence of impaired renal function. Serum levels of 10-15 $\mu\text{g./ml.}$ four hours after a dose in two of the patients (Fig. 13) are higher, and mean concentrations of 920 and 760 $\mu\text{g./ml.}$ of urine after 1 g. q.d.s. (Table 1, Cases 5 and 7) are lower than we would expect in normal people. Davies, Strangeways, and Holt² investigated the absorption and excretion of cephalixin in patients who had suffered with anaemia following partial gastrectomy some years previously, and in patients with pernicious anaemia, obstructive jaundice, or chronic renal failure. The only patients who showed a difference in urinary excretion from normal were those with chronic renal failure. In patients with impaired renal function (24 hour endogenous creatinine clearances of <10 ml./min. to 77 ml./min.), Bailey, Gower and Dash³ recovered in the urine 23-78% of a single 500 mg. dose of cephalixin. In the group with creatinine

clearances of <10 ml./min. a mean of 37% was recovered in 48 hours, although urine concentrations above 66 $\mu\text{g./ml.}$ were maintained for 36 hours in a subgroup studied between courses of twice-weekly haemodialysis. If the renal function of the patients reported by Dr. Gaya and colleagues was normal then their paper appears to be unique with regard to the low excretion rates.

In normal people, experiments using single doses (125 mg.—1 g. of cephalixin have been reported from many centres⁴ and the results have been consistent: high percentage recoveries ($>70\%$), sometimes within six hours of the dose. In addition O'Callaghan (personal communication) has performed many separate experiments on normal volunteers, numbering in excess of 120, with similar results—almost complete recovery of cephalixin in urine. A minority of people experienced some delay in absorption, peak serum levels being reached up to four hours after the dose; even so, urinary recoveries were normal. This may account for the finding of Leigh, Faiers, and Brumfitt⁵ who reported variable recoveries in the urine of normal volunteers: from 40% to 100% in the first six hours after a single 500 mg. dose of cephalixin.

We are not aware of other published papers reporting 24-hour urinary recoveries after several days of cephalixin therapy in patients with normal renal function. There is no reason to suspect the urinary excretion rate will decrease after repeated dosage.—We are, etc.,

Clinical Research Department,
Glaxo Laboratories Ltd.,
Greenford.

C. H. DASH.

Department of Medicine,
Fulham Hospital,
London W.6.

P. E. GOWER.

REFERENCES

- 1 Jambon, M., Bertrand, A., Roux, J., and Jambon, F., *International Journal of Clinical Pharmacology, Therapy and Toxicology*, 1969, Suppl. No. 2, 31.
- 2 Davies, I. A., Strangeways, Janet E. M., and Holt, J. M., *Postgraduate Medical Journal*, 1970, Suppl. 46, 16.
- 3 Bailey, R. R., Gower, P. E., and Dash, C. H., *Postgraduate Medical Journal*, 1970, Suppl. 46, 60.
- 4 Symposium on Clinical Evaluation of Cephalixin, Royal Society of Medicine, 2 and 3 June 1969.
- 5 Leigh, D. A., Faiers, Mary C., and Brumfitt, W., *Postgraduate Medical Journal* 1970, Suppl. 46, 69.

Hepatic Carcinoma and Haemoperitoneum

SIR,—Mr. A. P. Ross's account of portal hypertension presenting with haemoperitoneum (28 February, p. 544) prompts me to report a case of haemoperitoneum seen at the Queen Elizabeth Hospital, Umuahia, East Central State, several years ago.

The patient was a young man who also had 6 pints (3.4 litres) of blood in the peritoneal cavity. The liver was coarsely nodular and showed neoplastic change, with a bleeding area on the anterior surface, where the growth had ulcerated through the capsule.

I have seen a number of cases of primary carcinoma of the liver, but no other complicated by haemoperitoneum. It is interesting to speculate whether the carcinoma itself was the basic cause of the bleeding, or if there were intrahepatic portal-systemic anastomoses associated with invasion by malignant tissue. If the latter, this would

seem to be another case of portal hypertension presenting with haemoperitoneum. From memory, biopsy showed portal cirrhosis with malignant change. We had no facilities for biochemical investigation.

It may interest those of your readers who are considering work in the developing countries that the emergency case immediately preceding this young man was a woman who also had 6 pints of blood in the peritoneal cavity. She had a ruptured tubal pregnancy, and the blood was collected, citrated, and returned to her. Recovery was uneventful.—I am, etc.,

MARJORIE L. PENWILL.

Methodist Hospital,
Ituk Mbang,
Nigeria.

"Marginal Surgery"

SIR,—Mr. J. M. Potter (5 September, p. 584) asks what can be done for the severely brain-damaged patient whom apparently nobody wants to care for. There is one largely unrecognized type of hospital which can provide much of what the patient needs: hospitals for the mentally retarded have staff and facilities for looking after patients who are mentally handicapped, paralysed, and epileptic. The condition of a man who has been injured in an accident may not be essentially different from that of a child after severe meningitis.

I would like to quote one case. A man of 22, of apparently average intelligence and good physical health, suffered a severe head injury. Lacerated brain-tissue was removed and a subdural haematoma drained in a neuro-surgical unit, and the patient was then transferred to a general hospital in which he stayed for a year before he was admitted into this hospital for the mentally retarded.

On admission here he was unable to walk, had 100% impairment of his right side, and 50% impairment of the left; had no speech; had been fed through a nasal tube; was incontinent of faeces; had an indwelling catheter; had an open tracheostomy; was at times aggressive; had not been home since his accident. In this hospital he has been treated by doctors, nurses, psychologist, physiotherapist, speech therapist, and music therapist. Now, 9 months after admission, he can walk with a walking aid, feed himself with all meals using ordinary implements, speak a few words, has almost full control of his bladder and 70% control of his bowels, has not been aggressive, and goes home for weekends every fortnight. His tracheostomy was closed and his catheter removed shortly after admission. He is continuing to improve.

I would like to suggest that a neurosurgeon faced with such a patient should consider the facilities that the local hospital for the mentally retarded can offer.—I am, etc.,

J. GIBSON.

St. Lawrence's Hospital,
Caterham, Surrey.

Biological Detergents

SIR,—Lately there have been several reports of the harmful effects of biological detergents on the skin and respiratory system.^{1,4} Recent experiences of a patient of mine suggest a possible risk to the eye.

The patient, a widow aged 63, developed a marked bilateral conjunctivitis in July 1970. When questioned, she stated that she had noticed a stinging sensation of the eyes whenever she tipped a new brand of washing powder into water. This powder, which she had used for a few weeks only, proved to be a well known enzyme detergent. On giving up the use of the preparation the conjunctival signs disappeared and have not returned.

Presumably the act of tipping out the washing powder can give rise to a sufficient concentration of enzyme dust to affect the conjunctiva of a sensitive person. When dealing with an unexplained case of allergic

conjunctivitis, therefore, it seems worth asking whether the patient has been using a new brand of washing powder.—I am, etc.,

A. P. RADFORD.

Bristol.

REFERENCES

- 1 Jensen, N. E., *British Medical Journal*, 1970, 1, 299.
- 2 Bamji, E., and Bamji, N., *British Medical Journal*, 1970, 1, 629.
- 3 Newhouse, M. L., Tagg, B., Pocock, S. J., and McEwan, A. C., *Lancet*, 1970, 1, 689.
- 4 Pepys, J., Hargrave, F. E., Longbottom, J. L., and Faux, J., *Lancet*, 1969, 1, 1181.

Pay of Medical Assistants

SIR,—As medical assistants employed full-time or maximum part-time in a wide variety of specialties we wish to express our disappointment and concern that the recently announced exceptions to the 20% increase, to adjust salary relativities, do not include medical assistants appointed before 1969.

The award of a 30% pay increase to senior registrars and 20% to medical assistants has resulted in a difference of up to £312, point for point, between the two scales, instead of a maximum difference of £30 before the increase. Now, a medical assistant at his 8th point earns less than a senior registrar in his sixth year.

While new entrants to the grade may be

assimilated at an appropriate point to counteract the altered differential, those already at the 2nd to 9th points on the scale are to be paid less than colleagues of equal or fewer years experience in the senior registrar grade. This, we maintain, is unjust.—We are, etc.,

M. K. BEDARKAR.	R. E. GILLSON.
MICHAEL BUTLER.	A. D. HARRIS.
ANGELA E. DIKE.	A. L. MCKNIGHT.
PATRICIA M. GILHAM.	JOAN D. RIVETT.
MARGARET F. GILLISON.	THAN NYUNT.
MARY M. THALANANY.	J. D. S. VERNON.
M. A. K. KAREENU	MARGARET R.
	WOLFENDALE.

Hospitals of the Oxford Regional
Hospital Board.

Certification and the General Practitioner

SIR,—The aim of negotiation is a quid pro quo. It seems inevitable now that the pay award is to be whittled down by 5% in spite of the compelling case made out by the Review Body for its immediate implementation. That is the quid: and the quo?

This is the time to take certification for insurance purposes out of the hands of general practitioners. It has been demonstrated

that neither patient nor State lose by this, while the benefit to general practitioners would be the removal of the greatest single obstacle to good medical practice.

If doctors forgo 5%, then doctors forgo certification. This deal seems obvious, but I have yet to see it suggested in print.—I am, etc.,

JOHN FOSTER.

Barnsley, Yorks.

Discretion and Ethics

SIR,—I have heard some doctors talking to their wives about their patients: that is a gross breach of medical ethics. As a warning it would be useful if the details of a historic trial be republished in the *B.M.J.*

Dr. William S. Playfair, professor of midwifery, King's College, London, performed an operation on a patient and spoke to his wife about it. She repeated the details to her women friends, who, in their turn, repeated it to their women friends till the story reached the ear of the patient. She

sued Dr. Playfair for slander. The year of the trial was 1896; the trial judge was Sir Henry Hawkins, the famous "hanging judge" (afterwards Lord Brampton). The jury awarded the plaintiff a large sum.¹—I am, etc.,

S. S. VAZIFDAR.

Berkhamsted,
Herts.

REFERENCE

- 1 *British Medical Journal*, 1896, 1, 815, 869, and 882.

Points from Letters

Upgrading V.D. Departments

DR. M. P. VORA (Bombay, India) writes: I have been following with great interest the correspondence that is going on the topic of changing the name of venereology. Mr. A. J. King's reply (4 July, p. 46) is clear, appropriate, and emphatic. . . . Venereology must be given its due place and importance to maintain standards of training, education, to promote research, and to control V.D. effectively. It is a matter of great regret that most Indian universities have still to recognize venereology as an independent speciality and realize its importance. The sooner they do it the better it will be.

Living it up with Concorde

DR. G. A. CHRISTIE (Medical Director, Syntex Pharmaceuticals Ltd.) writes: Dr. K. G. Heymann (3 October, p. 53) suggests that Concorde will cause greater disruption of the biological clock than present flight patterns. In point of fact it is likely that the traveller who proceeds to New York, attends a business conference, and returns in the same day, will suffer no disruption whatsoever, as insufficient time for such upset to commence will be present. Precisely this has been demonstrated in quick return flights from Paris to Anchorage by Air France, working with non-experienced travellers. . . .

Crisis in Venereology

Mr. D. HILL S.R.N. (Special Clinic, Coventry and Warwickshire Hospital, Warwicks.) writes: It was very enlightening to read the article by Drs. R. D. Catterall and R. S. Morton (19 September, p. 699) for now it is apparent with what degree of esteem they regard their nursing staffs and how concerned they are regarding their pay and conditions. If one considers the previous survey of over four years ago when the then Ministry of Health issued a circular regarding the male staff position in V.D. clinics (H.M. (66) 50), which was even then serious, then this article appears to be too one-sided and feeble instead of offering positive action and considering all grades of staff—including nurses. But it would seem that the medical staff are too concerned with their own problems to give support for the nursing staff who in some clinics do more than their fair share of the work. . . . One has often regarded doctors and nurses as part of a team. Well, it's about time this was put into practice. Nurses should no longer be regarded as the servants of the doctor but as trained colleagues with the same aim in view—namely, the care of the patient, and as such should be involved in any discussions to achieve this aim. There is no doubt that unless a concerted effort is made by all concerned, there will be no service at all in the future.

Fascioliasis

DR. A. T. HUNT (Divisional Health Office, Coleford, Glos.) writes: All the patients described by Dr. E. W. Hardman and others (29 August, p. 502) had eaten from a source of wild watercress. . . . Cultivated watercress should be regarded as free of this danger, as professional growers take precautions to avoid the drainage of animals as recommended by the report of the working party of the Public Health Laboratory Service of 1966 on the hygienic production of watercress. Inspections are now made of green-grocers in my area to ascertain that only labelled cultivated watercress is sold, but as the growth of wild watercress cannot be controlled nothing but publicity and education will prevent individuals from picking and eating it. An isolated case occurred in a nearby rural district in a farmer's wife. She ate watercress from a particular shop which sold only that from a professional grower (and this could not have been suspect). Watercress grew on her farm but she never ate this. She did assist in preparing drenches and injections for her husband to give sheep, which were heavily infested (he lost 11 ewes from fluke), and hence probably picked up the *Metacercaria* on her hands from which she accidentally ingested them. . . .

Risks from Pets

Dr. J. J. SEGALL (London N.W.2) writes: Professor A. W. Woodruff's paper on toxocarasis (19 September, p. 663) reinforces the need for pet owners to ensure the hygienic disposal of their animals' excreta. Local authorities should be required to encourage or provide appropriate means for this purpose. Bye-laws on this subject should be made more stringent, and an attempt made to enforce them.

Urethral Syndrome

DR. PAMELA WRAY (Ipswich) writes: I was surprised that Dr. A. J. Wing (26 September, p. 753 and 3 October, p. 35) did not include gonococcal infection, trichomonal infestation, and non-specific urethritis in his list of causes of "the urethral syndrome." As any venereologist can confirm, the diagnosis of these three conditions is very often missed, particularly in the female patient; firstly, because they are not considered, and, secondly, because the mid-stream specimen of urine may well be sterile. It is advisable to take urethral smears and cultures from any woman with the urethral syndrome. Unfortunately the commercial swabs are too well padded for a satisfactory specimen to be taken from inside the urethra of most women and many men. . . .