Promiscuity and infertility

SIR,—Your leading article (30 August, p 501) notes the increase in salpingitis after gonococcal infection. However, *Neisseria gonorrhoeae* is still difficult to isolate in salpingitis. A recent survey at a South Wales hospital has shown 29% of salpingitis cases (excluding post-abortal) to be gonococcal.[1] This figure was obtained in a gynaecological unit possessing the organisation, equipment, and expertise for diagnostic precision which, you rightly say, is often lacking. Two other hospitals with the same catchment area but without the same facilities had figures of 3% and 1%, which are probably representative of most hospitals.

The bacterial aetiology of non-gonococcal salpingitis is poorly understood. Many cases probably represent infection by opportunist bacteria of tubes already damaged by previous infection, either gonococcal or from adjacent pelvic viscera. Secondly, chlamydiae and T-strain mycoplasmas are becoming increasingly recognised as major causes of non-specific urethritis in males, which is now diagnosed more frequently than gonorrhoea.[2] The equivalent infection in the female is difficult to identify and may be represented by non-gonococcal salpingitis. If so, the common treatment of non-gonococcal salpingitis with penicillins such as ampicillin is irrational, as these organisms are insensitive and respond best to tetracyclines. Inappropriate antibiotic therapy would explain the tendency for relapse in this condition.

A clue to the cause of infection may be provided by inquiring about urinogenital troubles in sexual contacts. Patients do not usually volunteer this information unless specifically asked. The venereologist should be consulted more often by his gynaecological and surgical colleagues in the investigation of patients with possible salpingitis, as he possesses the necessary clinical background to utilise correctly the bacteriological diagnostic techniques available.

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Hibiscrub in acne

SIR,—An advantage of the phenolic type of disinfectant is its compatibility with soap, which enables formulations to be prepared which cleanse and disinfect simultaneously. Reports of dermal absorption of hexachlorophane[1-4] resulted in restrictions being placed on preparations containing it,[5] which may affect its use for, among other indications, the treatment of acne. At about the same time that moves were being made to limit the use of hexachlorophane in the United Kingdom Hibiscrub, a detergent disinfectant containing 4% Hibitane (chlorhexidine), was released. Its effectiveness as a skin disinfectant has been reported.[6-8] A trial was undertaken at this hospital to assess its tolerability by patients with acne.

A total of 48 patients suffering from all grades of acne attending the outpatient clinic were advised to gently wipe their forehead, cheeks, and chin, avoiding contact with the eyes and lips, morning and night with balls of cotton wool soaked in Hibiscrub. A total amount of 10 ml was used for a single application. Immediately after the application the whole face was to be rinsed thoroughly at least twice with fresh running water. The patients were supplied with written instructions to this effect. They were examined at fortnightly intervals for one month, when any evidence of erythema, oedema, itching, or pain was particularly looked for. Forty of the patients showed satisfactory progress over the whole trial period: 9 of them cleared up completely, 8 improved, and 4 others tolerated the treatment better than some other products they had previously used. Of the 8 who made no progress 3 had reactions which were severe enough for them to stop treatment on their own initiative. One of them had atopic eczema, another had received a course of topical steroids, while the third had a drier skin than is normally seen with this type of patient. Four other patients reported mild erythema or itching severe enough to make them stop the treatment. One patient failed to attend and follow-up correspondence produced no response.

Since most of the patients were satisfied with the treatment, many asking that they should continue with Hibiscrub, it would seem reasonable to carry out a comparative trial of the preparation with some other application commonly used in acne.

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Test of general practice trainees

SIR,—Recent discussion about the Temporary Registration Assessment Board (TRAB) examination prompts me to make a preliminary report on the findings of a test carried out for another purpose.

In September 51 trainees in their general practice year answered a paper consisting of 220 multiple choice questions. This paper was kindly supplied by Professor P S Byrne and the questions were similar to those previously presented in the MRCGP examination, being of a clinical nature and covering the specialties relevant for general practice. The candidates were not aware that an examination was to take place and had therefore not prepared themselves. Some of the overseas graduates had been in this country more than 10 years. All were registered.

Of the 24 United Kingdom graduates 22 obtained more than 100 total marks. Of the 27 non-UK graduates three obtained more than 100 out of 220. Negative marking was employed. The range of marks was from 12 to 152. It is interesting to note that a non-medical research assistant, employed in this department, obtained 63 marks and 10 of the overseas graduates obtained fewer than that. The overseas graduates tended not to finish the paper even though they were offered extra time, and some of them took up this offer. To allow for this, the answers have been analysed based on a percentage of marked answers actually given. If a 45% pass mark is applied then, on this basis, all UK graduates passed and 7 out of 27 non-UK graduates passed.

It may well be that by self-selection these trainees are an example of the better quality doctors who are entering general practice and have been doing so over the past few years. Even if this is not so and even though the test has been only of a small facet of their potential, these results would indicate that the problem being inherited by general practice is much greater than other reported results have so far indicated.

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Prazosin in treatment of hypertension

SIR,—Several cases of hypertension episodes at the start of treatment with prazosin have been reported.[1-3] We did a cross-over comparative trial of hydrallazine and prazosin in 15 outpatients on continuous treatment with a beta-adrenergic blocking drug (propranolol). A test dose of 1 mg prazosin was given at dinner, and the patient was told to stay home for the rest of the evening. If this dose was well tolerated treatment continued the next day with 1 mg thrice daily, whereafter the dose was increased as needed. Our highest dose was 15 mg daily.

No hypertensive episodes or side effects were seen except in one patient, who developed severe headache two hours after taking the test dose. Three days later the patient, on his own initiative, took another test dose with exactly the same result. He resumed hydrallazine therapy without side effects. Thus the mechanism by which hydrallazine and prazosin provoke headache seems to be different.

Our study showed that 25 mg of hydrallazine corresponds to 0·84 mg prazosin. A starting dose of 2 mg prazosin thrice daily, which is often used, is therefore equal to 60 mg hydrallazine three times daily—a dose which nobody would use to start with. We believe that hypotensive episodes could be avoided by using a smaller initial dose of prazosin. Generally we would recommend 0·5 mg three times a day.

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Medical terminology

SIR,—Whereas as a physicist I hesitate to write to you—and particularly on that most complex of areas in medicine, terminology—I feel strongly that the time is ripe for some adjustment to conventional usage to remove its blatant historical bias. The adjustment may be supported on four grounds: firstly, to assist new entrants to the medical profession; secondly, to assist those working in paramedical disciplines (who may not be too conversant with the intricacies of medical terminology); thirdly, to maintain the usefulness of classical languages in understanding