screening test. Negative plates and those with light or mixed growth can be confidently discarded. A heavy pure growth in a culture is designated positive, whatever the result confirmed by our routine method. Identification and sensitivity testing can be performed on the primary growth, and where necessary treated immediately without awaiting confirmatory results. While proper mid-stream specimens are desirable we suspect that some are not always obtained, and immediate direct plating reduces the growth of contaminants to a minimum. If patients bathe before attending clinic vulval cleansing appears unnecessary.

This method has been compared with our semi-quantitative method, which is essentially the same as that of Guttmann and Stokes, on 350 antenatal cases and 100 others. No significant discrepancies were found, and the incidence of bacteriuria of pregnancy demonstrated was 6%, correlating well with other series. It is also currently in use in investigating asymptomatic bacteriuria of non-pregnant women, and in an investigation in general practice. Inoculated plates can be sent direct to the laboratory for incubation, but urinary pathogens will grow, though more slowly, at room temperature. Plates can therefore be inoculated and kept by the practitioner, and only "positive" sent for identity and sensitivity testing. The key plates inhibit the swarming of Proteus species, and at room temperature keep without deterioration for considerable periods, especially in plastic bags. They are readily available from routine stock in all laboratories, and dare one suggest that pre-poured plates might eventually become available through the Ministry for domiciliary use.

This is, we believe, a really simple test which should be easily available to all doctors and their patients.—We are, etc.,

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REFERENCES

Oral Contraceptives, Thrombosis, and Cyclical Factors Affecting Veins

Sir,—The following case of thrombophlebitis in an antecubital vein is being reported, first, because the patient had been taking oral contraceptives, and, secondly, to draw attention to clinical relationships between the venous system and the cyclical endocrinomechanism.

In May 1963 a lady of 27 was referred to me during the fifth month of pregnancy on account of varicosities and congestion of the right lower limb. She had had one previous child, a subsequent miscarriage, and her medical history had been very good. The pregnancy proceeded normally, but the patient did not return after the birth of her baby for me to see the condition of her veins.

The patient consulted me again in August 1963, 1 month of pregnancy. The veins and the skin discolouration in the right lower limb were worse than they had been in the preceding pregnancy. During the course of the consultation the patient volunteered the information that somewhere about the time of conception there had been trouble with a vein in the right antecubital fossa. The vein had become raised, prominent, firm, and tender; there was also redness and irritation of the skin; and these symptoms cleared up within a month to resolve. The patient indicated that the trouble had been in a long and rather unusually placed median basilic vein, but at the time of my examination she had no varicose veins in the right arm.

As the patient was a very intelligent observer I felt no doubt that she had had an attack of thrombophlebitis. There had been no previous history of phlebitis or thrombosis, no active treatment to her varicose veins, and no trauma to the antecubital region. A general examination and all relevant investigations were normal. The patient had started these in November 1963, some 2 months after the birth of her second baby, Ovenel. I suspect that these had never been taken absolutely systematically and she attributed this to forgetfulness. She added that she always felt lachrymal and "not quite normal" when taking contraceptives, and looked forward to the days when she was not taking them. The pregnancy was not a planned one, but it was impossible to find out more details concerning either the regularity with which the contraceptives had been taken or the date when they had been given up. The patient had said that she had left the contraceptive pill 1 month before the right lower limb which first suggested the possibility of pregnancy to her.

I have seen very large numbers of cases of thrombophlebitis in the superficial veins of the limbs and have always been in a condition with considerable suspicion when occurring in an apparently normal vein, especially in a vein of the upper limb. Superficial thrombophlebitis in the arm and forearm is very rare except when secondary to intravenous procedures for diagnostic, anesthetic, or therapeutic purposes, or in association with gross trauma. Excluding cases following axillary thrombosis and those developing during the course of thrombophlebitis migrans there appears to be a case of thrombosis in an antecubital vein in the absence of some clearly defined cause.

Certain other factors which should, I think, be borne in mind in this connexion:

There is certainly a very close relationship between the superficial venous system and the cyclical changes in women. This is brought out strikingly in the case of the age incidence of the development of varicose veins in women. Such a group is a definite group where the veins develop at puberty, and in this group the hereditary factor is dominant. The second and third month of pregnancy, and in my experience the development or aggravation of varicose veins invariably occurs at a very early stage, usually about the second month, and long before merely mechanical factors can play any part. Thirdly, there is a small group of cases where varicose veins develop for the first time around the menopause, or are markedly aggravated at this stage. On the other hand, the development of varicose veins for the first time in the post-menopausal woman is almost unknown.

Further evidence as to an endocrine relationship is provided by the changes in the superficial veins which occur in some patients during the premenstrual phase. Many years ago I saw a young woman who complained of a large vein on the outer aspect of the thigh, which became prominent. I saw this patient on several occasions, her observations were entirely correct, and no other venous abnormalities were present. Apart from the week or so preceding a period the veins were more prominent, but their walls cutaneous vein, while in the week preceding the period the vein was grossly enlarged, raised, and prominent. In a few patients with established varicosities subjective or objective phenomena related to the veins or to associated skin congestion may, as in the case now reported, be the first indication of a possible pregnancy. The clinical evidence, therefore, suggests that there is a close relationship between the superficial venous system and the cyclical endocrine changes in women.

Although there are many gaps in the evidence in the present case, I feel that the development of superficial thrombophlebitis in an antecubital vein must be regarded with some suspicion in a patient who had been taking oral contraceptives. It may also be possible that gauroxan has shown hepatotoxic effects in some patients. Further studies are in progress to clarify the situation.

Meanwhile we feel that gauroxan (a most powerful hypotensive agent) should be used only where careful haemodynamic control is possible.—We are, etc.,

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Side-effects of Gauroxan

Sir,—In his article on hypotensive drugs (Prescribers' Journal, Vol. 5, No. 4) Dr. Richard Turner mentions some side-effects of gauroxan. We feel it our duty to report that in our extended clinical trial of this drug currently in progress at the Whittington Hospital we have seen no evidence that gauroxan has shown hepatotoxic effects in some patients. Further studies are in progress to clarify the situation.

Meanwhile we feel that gauroxan (a most powerful hypotensive agent) should be used only where careful haemodynamic control is possible.—We are, etc.,

ACUTE PANCREATITIS

Sir,—In the article the "Treatment of Acute Pancreatitis with Trasylol" (Prescribers' Journal, Vol. 5, No. 4, 1965, p. 627) the authors state that Trasylol was of no benefit to patients but that actually "the Trasylol group fared worse than the controls." I must say I read this report with some surprise, as I had formed the impression that Trasylol was of benefit in the treatment of acute pancreatitis, and also many of my surgical colleagues agree with this impression. My remembrances of pancreatitis during a long clinical career have led me to regard this condition as a very serious and often lethal one. Since using Trasylol I have had eight cases of acute pancreatitis, all submitted to laparotomy and all very severe acute cases; not one patient has died and they have all remained alive after almost complete necrosis of the pancreas. The very last case in my series before the Trasylol era perished.

I have come to regard this drug as a valuable one in the treatment of acute pancreatitis, and we have had no side-effects even when using the drug in very high dosage. I am fully conscious that eight cases constitute only a small number upon which to make an ex cathedra pronouncement, and I know that clinical impressions are not infallible but nevertheless I attach considerable weight to such clinical impressions as affording valuable evidence as to whether a drug is of value or not.