unters on the off-chance that their organs might one day be suitable for transplantation.

It would have been more appropriate if the subcommittee had directed attention to the main ethical dilemma of organ transplantation—namely, the fact that only some 10% of the 2,000-3,000 young people needing treatment for terminal renal disease are being helped, the rest being allowed to die, despite the established fact that many of them would be provided with worthwhile therapy if more donor kidneys were available.

A change in the law with provision for "contracting out" is the only way in which there can be a solution to the shortage of donor organs. This was accepted by the majority of the MacLennan committee and legislation along these lines has already been adopted in Denmark, France, Israel, Italy, and Sweden.—I am, etc.,

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Chemotherapy of Bronchitis

Sir,—In your leading article on the chemotherapy of bronchitis (17 January, p. 125), a combination of fucidin and cloxacin is suggested as an orthodox treatment for staphylococcal pneumonia. However, you then observe that these antibiotics may be antagonistic under in vitro conditions. You therefore recommend a combination of fucidin with erythromycin for staphylococcal pneumonia. Not only is there no possibility of antagonism, but erythromycin may be more effective than cloxacin against pneumococci, which may also be present.

Antagonism between fucidin and the penicillins, demonstrated by Eriksen,1 is found when staphylococci are incubated for 24 hours in the presence of both antibiotics. Because of the inhibitory effect of fucidin, the staphylococci do not multiply and cannot therefore be destroyed by the otherwise bactericidal action of penicillin. However, this type of observation cannot be applied directly to conditions in vivo. It is also important to show if antagonism can be demonstrated after more than 24 hours, as a period of treatment of only 24 hours has no relevance to clinical practice. An investigation done in collaboration with K. A. Jensen (unpublished observations) showed that while antagonism can be observed after 48 hours' incubation of the pneumococci in the presence of the two substances, after 72 hours only very few staphylococci survived the combined effect. After five days, no antagonism can be shown. This corresponds much better with the conditions in vivo where treatment is normally continued for at least a week.

On this basis we have treated 86 cases of staphylococcal pneumonia (72 cases of pneumonia due to a combination of fucidin and methicillin and 27 cases of acute respira-
tory tract infection caused by staphylococci, with a mortality of 46%; 27 patients were treated with oxacillin with a mortality rate of 44%; and 24 patients were treated with diphencillin with a mortality of 67%.

Martin et al.3 treated 23 patients with penicillinase-stable penicillins, observing that 61% of the deaths were due directly to staphylococcal infection.

A treated with penicillinase-negative penicillins, by current routine techniques, may indeed have little relevance to what actually happens in practice.—I am, etc.,

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REFERENCES

Haemolytic Anaemia in Pregnancy in Nigerians

SIR,—I read with interest the article by Drs. A. F. Fleming and N. C. Allan (22 November, 1969, p. 461) on "Severe Haemolytic Anaemia in Pregnancy in Nigerians Treated with Prednisolone." The conspicuous absence of a reference to glucose-6-phosphate dehydrogenase deficiency (and, incidentally, to serum iron levels) needs a little comment.

Edington and Gilles1 state: "G-6-PD deficiency plays an important role in the pathogenesis of a variety of haemolytic anaemias in the tropics." Now in West Africa between 10 and 15% of the populace is homozygous with a partial deficiency of this enzyme. Urinary tract infection in pregnancy is as common in West Africa as it is in Europe. Moreover West African countries use as a rule no treatment other than the opening of the drug which elsewhere can be dispensed only in hospitals, at chemists, or in a pharmacy. Quacks also abound: Therefore patients often come to hospital having already dosed themselves with chloramphenicol and/or nitrofurantoin—two drugs which appear in a recent list by Bredt and Dr. Allan's list of some common drugs which may induce haemolysis of G-6-PD-deficient red cells. It is my clinical impression that here in Accra the total defect of the female (hemoglobin) is more severe than that of the male (hemoglobin). The haemolysis of the female total defect seen here in Accra can sometimes be so catastrophic as to precipitate acute renal shut down.

Having myself seen in Korle Bu Hospital cases of severe haemolytic anaemia with obscure hepato-splenomegaly in pregnancy, I hasten to concede that the type of "severe haemolytic anaemia in pregnancy in Nigerians" described by Dr. Fleming and Dr. Allan is quite unlike haemolysis due to G-6-PD deficiency. Nevertheless this hereditary quantitative erythrocyte defect could have played a minor role in one or two of the cases described, and should have been excluded just as a major qualitative haemoglobinopathy was excluded.

Incidentally, apart from the factors mentioned in the excellent discussion of Dr. Finlay and Dr. Allan's article, I would like to add other things to suspect in haemolytic anaemia of obscure origin during pregnancy in a non-sickler mother: Thalassaemia minor,2 Hb CC disease,3 and systemic lupus erythematosus.—I am, etc.,

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Gongential Goitrous Cretinism due to Iodide

SIR,—The ingestion of iodides by theexpectant mother is a documented cause of gongential cretinism in the infant. Cases still occur despite recognition of the hazards of proprietary substances containing iodides.

A male infant weighing 5 lb. 8 oz. (2.5 kg) was admitted to the Stobhill Hospital nursery on 19 June 2021 by guest. Protected by copyright.http://www.bmj.com/ Br Med J: first published as 10.1136/bmj.2.5701.112-a on 11 April 1970. Downloaded from http://www.bmj.com/ on 19 June 2021 by guest. Protected by copyright.