Training of Physicians in the N.H.S.

SIR,—Even if there were the remotest chance of its being implemented the scheme proposed by Dr. M. Hamilton and Dr. H. Kopelman (23 January, p. 223) would accomplish little. I imply no criticism of their ideas in the context of the Health Service as it exists at present; certainly their suggestions would improve the experience of junior doctors and bring some order into the extremely casual and wasteful way in which doctors now float to the top. However, the frustrations and dissatisfaction they refer to will not be removed by only revising existing training opportunities.

The entire career structure of doctors in the Health Service needs revision. The prospect of indefinite "training" should be replaced by a limited (however long), organized programme which systematically provides experience in all aspects of the specialty. The prospect of indefinite servitude to and dependence upon senior members of the profession should be replaced by the possibility of an independent, if junior, staff position at an age when the doctor's most productive years still lie ahead. From such a position a man could rise according to his ability, energy, and ambition. Possibly most important, the Service should be flexible enough to allow investment of its facilities and funds in the person rather than in the post. The prospect of "trainees" waiting for vacancies to occur even when there is a clear need for their services in demoralizing—for example, the senior registrar's *obiter dictum*: "where there's death there's hope." But having achieved his goal, the consultant post, still the prospect of very capable doctors having their abilities wasted in a peripheral hospital only because those hospitals have been decreed "peripheral" by the Service is demoralizing.

It seems fruitless to propose a scheme to fit junior doctors into a system which is basically unattractive even if, as I say, there was the slightest chance of its implementation.—I am, etc.,

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Induction of Therapeutic Abortion with Urea

SIR,—I quite agree with Mr. A. Pugh and others (6th February, p. 345) that the amniocentesis-abortion interval using intra-amniotic urea is too long. In the ten cases described in a preliminary communication by Mr. P. L. C. Diggory and myself (2 January, p. 28) the average termination interval was 58 hours.

Since the time that article was submitted for publication I have performed another 50 terminations of pregnancy with urea in the mid-trimester, this time oral oxytocin being used 24 hours after the amniocentesis if there were then no uterine contractions. With this regimen the interval was reduced to 48 hours. The mean gestational age in these 50 cases was 16.2 weeks. Curettage was required in 17 patients, 10 because of failure of the uterus to contract after 96 hours of amniocentesis though the fetal heart could not be detected with the Sonicaid machine and seven others because of an incomplete abortion. Of the former, nine were at 14 weeks gestation and one at 16 weeks. Ampicillin was prescribed in 4

patients because of pyrexia of 100°F. (37.8°C.) although cervical swabs, were sterile on culture in two of these.

More recently in more than 20 mid-trimester cases of terminations a Syntocinon (synthetic oxytocin) drip of 40 units per litre has been set up immediately after the amniocentesis. With this regimen the amniocentesis-abortion interval is much shorter than before.

In view of the occasional technical difficulty in performing amniocentesis at 14 weeks and the high incidence of failed abortion requiring curettage, this method does not seem suitable at this stage of gestation, although for pregnancies of 16 weeks and over it is very useful.—I am, etc.,

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Cryptococcal Meningoencephalitis and 5-Fluorocytosine

SIR,—Some time ago a report appeared on the successful use of 5-fluorocytosine in the treatment of a patient with cryptococcal meningitis.¹ It was rather hastily concluded that this antifungal agent, which combines the advantages of oral administration with relative freedom of side effects, might replace amphotericin B as the first choice in the treatment of cryptococcosis. A few other patients with *Cryptococcus neoformans* meningitis have since been treated with 5-fluorocytosine and in all except two satisfactory immediate clinical response was reported.²⁻⁴ As it is clearly impossible to await the results of extensive clinical trials before adopting a new drug for the treatment of a rare condition, we consider that it is both scientifically and ethically justified to report here on an isolated therapeutic failure of 5-fluorocytosine.

A 34-year-old man received a paternal kidney transplant in November 1968 following nephrectomy for chronic glomerulonephritis. After uneventful postoperative recovery he was maintained on an immunosuppressive regimen of antilymphocytic serum, corticosteroids, and azathioprine. In February 1970 he presented the first signs of meningoencephalitis and *C. neoformans* was grown from a C.S.F. sample obtained on 17 April. As amphotericin B seemed precluded for its nephrotoxicity, treatment with 5-fluorocytosine was initiated on 16 May. The drug was given by gastric tube at the dose of 6 g per day. After 45 days' treatment the patient's condition was satisfactory and as four successive cultures of the C.S.F. had remained sterile, treatment was discontinued. After withdrawal of the drug the patient deteriorated and cultures became again positive. Treatment with 5-fluorocytosine was resumed on 15 July but the patient died in shock on 3 August. The fungus was grown from brain tissue obtained at necropsy.

Apart from a warning against over-enthusiasm for a new drug, this observation is instructive in several respects. Though cryptococcosis is far more frequent in the tropics, it is a cosmopolitan menace, even in a country like Belgium where only two cases of cryptococcal meningitis have been recorded.^{5,6} *Cryptococcus* infection is often associated with an underlying condition characterized by impaired host response. To the natural causes of such impairment iatrogenic causes have now to be added.

Immunosuppressive chemotherapy after transplantation is known to predispose to several types of systemic mycosis or pseudomycosis such as aspergillosis, candidosis, histoplasmosis, mucormycosis, and nocardiosis.^{7,8} Cryptococcosis constitutes a new addition to this list.

Microbiologists are often unaware of the many possible pitfalls in the diagnosis of cryptococcal disease. At no time were yeast cells discovered in India ink mounts of the C.S.F. of our patient. Colonies did not appear on the Sabouraud dextrose agar before ten days and they had not the classical mucilaginous aspect. Distinct capsules were seen only after the strain had been passed on mouse brain.

Cryptococcosis is a disseminated infection and in the majority of cases the fungus can be recovered from different sites, particularly from the urine.⁹ In our patient all urine samples examined were found positive for *C. neoformans*. Growth was more rapid and repeated samples easy to obtain. This is of practical importance in facilitating diagnosis and follow-up during chemotherapy.—We are, etc.,

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¹ Watkins, J. S., Campbell, M. J., Gardner-Medwin, D., Ingham, H. R., and Murray, I. G., *British Medical Journal*, 1969, 3, 29.

² Tassel, D., and Madoff, M. A., *Journal of the American Medical Association*, 1968, 206, 830.

³ Utz, J. P., et al., *Antimicrobial Agents and Chemotherapy*, 1968, 3, 44.

⁴ McDonald, R., Greenberg, E. N., and Kramer, R., *Archives of Disease in Childhood*, 1970, 45, 417.

⁵ De Busscher, J., Scherer, H. J., and Thomas, F., *Revue Neurologique*, 1938, 70, 149.

⁶ Yourassowsky, E., *Acta Clinica Belgica*, 1962, 17, 334.

⁷ Rifkind, D., Marchioro, T. L., Schneek, S. A., and Hill, R. B., *American Journal of Medicine*, 1967, 43, 28.

⁸ Haim, S., Better, O. S., Lichtig, C., Erlik, D., and Barzilai, A., *Israel Journal of Medical Sciences*, 1970, 6, 646.

⁹ Butler, W. T., Alling, D. W., Spickard, A., and Utz, J. P., *New England Journal of Medicine*, 1964, 270, 59.

A Case of Confidence

SIR,—The G.M.C. has got itself into a financial mess, but I now wish to draw your readers' attention to another mess created by them in the handling of the case of Dr. R. J. D. Browne (*Supplement*, 20 March, p. 79), when it found him not guilty of serious professional misconduct "because of the particular circumstances in this case" (Medical Act 1969). I contend that this verdict is neither fish nor flesh because the Disciplinary Committee threw overboard the Family Reform Act 1969 which gives the right to sixteen-year-olds to seek medical treatment without the parents' consent—about the Pill, V.D., etc. As a result it has now created the seeds of suspicion and mistrust among many, many patients who rightly seek confidential advice and treatment from their doctors.

I certainly do not uphold the actions of certain clinics in this country who put young unmarried teenagers on the Pill, but I will fight for the right that confidentiality shall be respected by all concerned irrespective of one's moral convictions. I am sure many of your readers will agree with me that the high standards of British medicine are based on the firm rock of confidentiality and mutual trust over many years.

Therefore, let us all, whether B.M.A. members or not, stand up and say to the