and transient swelling of face, body, and limbs (1); hypopyon of left eye (1); acute monarticular arthritis (1); and sulphonamide crystalluria (1).

Of the 12 meningococcal isolates obtained so far only one has shown sulphonamide resistance employing standard disc diffusion methods. Three of the four most recent strains to be isolated were from meningococci, the fourth belonging to group C. The minimum inhibitory concentration of the group B strains to sodium sulphadiazine was 1-6 μg/ml, and in two of them it reached 6 μg/ml. In meningococci, the resistance level is low, and the minimum inhibitory concentration of sulphonamide against meningococci is not the same. This may indicate the possibility of a gonoococcal cure. In a recent circular the Royal College of Obstetricians and Gynaecologists recommends trainees in obstetrics and gynaecology to consider a post in venereology as part of the elective year. This would be beneficial in developing an insight into the problems of gonochoex detection and control.—I am, etc.,

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Haemophilus influenzae Meningitis in Adults

Sir,—So far as I know, the interesting report by Dr. Susannah J. Eykyn and others (June 6) is the only one of its kind in the United Kingdom. It is unfortunate that as many of these cases as possible are not treated with immediate control and treatment. The practical relevance of this is that a capsule-swelling test with a good type b antiserum (such as that made by Hyland Laboratories) makes possible the firm identification of type b H. influenzae in C.S.F., even if they are few in numbers, within minutes of the arrival of the specimen in the laboratory.

Your leading article was a joy to read and I am sorry to have to point out any fault in it; indeed, the fault lies not in the article but in its title. A deal too with "Haemophi-

lus influenzae infections" but with one group of such infections, making no reference, for example, to the activities of non-capsulated strains in the bronchi, which account for the great majority of H. influenzae infections in Britain.—I am, etc.,

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British Medical Journal, 22 June 1974

Interaction of Nalidixic Acid and Warfarin

Sir,—It has been demonstrated in vitro that nalidixic acid can displace warfarin from binding sites on plasma proteins.1 This does not appear to be significant clinically.2 Dr. J. C. Petrie and his colleagues (4 May, p. 1219) in their interesting study of the awareness of selected drug interactions go so far as to call the nalidixic acid-warfarin interaction "theoretical." The following case suggests that nalidixic acid given to patients on warfarin can produce potentially dangerous excess anticoagulation and should be avoided.

A 55-year-old woman was knocked down by a car in March 1972 fracturing her pelvis and left femur. This was followed by a left ileofemoral venous thrombosis, venous gangrene of the toes, and acute renal failure requiring peritoneal dialysis over a period of several weeks. Her anticoagulation with warfarin was maintained after discharge and was well controlled with a prothrombin ratio around 2-0 on 11 mg/day ratio. The ratio was satisfactory on 20 December. She then developed an urticarial colt urinary infection and was given nalidixic acid 500 mg four times daily by her family doctor on 9 January 1973. She was readmitted to hospital on 14 January with a purpuric rash on her abdomen and bruise on her left leg and back, which came out on 17 January. Her prothrombin time was 45 seconds (control 13). The prothrombin time was not reduced on the warfarin and was discontinued. She was later discharged well with a prothrombin time of 22 seconds on 10 mg of warfarin daily.

I am, etc.,

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Antibiotic Preparations in the B.N.F.

Sir,—The section of the new edition of the British National Formulary3 dealing with Drugs Acting on Infections and Malignant Disease3 includes a number of statements which might be challenged. Some of these are listed below.

(1) Carbenicillin. It is advised that for stable infections or infections by continuous intravenous infusion. The data sheet issued by the makers advises that carbeni-

cilin be given intravenously either by bolus injection or rapid infusion on the grounds that infection over longer periods may result in subtherapeutic concentrations. Whatever the relative therapeutic merits of intermittent versus continuous administration, one is left with the other potential draw-

back of continuous infusion of the penicillins —that is, their possible inactivation by other components of the intravenous solution or incompatibility with other additives, notably gentamicin in the case of carbenicillin.

2 Ampicillin. Amoxicillin and its better absorption by the oral route should have been mentioned in a volume published in 1973.

3 Gentamicin. This is said usually to have "a slightly wider margin of safety" than kanamycin. In fact the margin between therapeutically active and toxic serum levels is greater with kanamycin.3 For some reason the intravenous use of gentamicin is vetoed, though this mode of administration must be widespread for serious systemic infections, notably with Pseudomonas aeruginosa.