Cendevax occurred in the Hospital for greater than one million newborns with congenital rubella syndrome (ICD-10: Q82). This administration of the antiviral IgG to the patient and her medical practitioner could be advised accordingly, but this has not occurred in our experience. It would probably be preferable, as suggested by Drs. Forrest and Menier, to have an IgG reaction with a high antibody titre, but as this is not generally available and because there are some variations in the antibody titre of the normal pooled IgG product, we have used a large number of 3, 5, and administered separate doses. Though this is considerably greater than what is advocated we think it is justifiable in the circumstances.—I am, etc.,

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References

Puerperal Rubella Vaccination and Anti-D Immunoglobulin

Sir,—Dr. Jill M. S. Forrest and Margaret A. Menier, reporting on 25 May, p. 430, that two patients in whom the use of immunoglobulin (IgG) prophylaxis caused delay in the serological response following exposure to rubella during pregnancy. Both infants were born with normal rubella defects. It may not be generally realized that the serological response obtained from vaccination against rubella in the puerperium may be altered by the concurrent administration of anti-D Ig to thalassaemic-negative women. We routinely take blood at the first antenatal visit for serological assessment of the patient's rubella immune status. In patients found to be susceptible vaccination against this virus is given before discharge from hospital following delivery. An efficient form of birth control is recommended for three months following vaccination. (The manufacturers of Almavex and Cendevax recommend that vaccination with their products should not be carried out within six weeks following the administration of human immune serum globulin. The reason for this contraindication is that the IgG could contain anti-rubella antibodies, which if present would reduce or negate any effect of giving the vaccine. Normal IgG usually contains between 160 and 320 units/ml of rubella antibodies and anti-D Ig apparently also contains rubella antibody within this range. The manufacturers of anti-D Ig state that it would be extremely difficult, if not impossible, to make a preparation free of rubella antibody. It would therefore be pointless to vaccinate against rubella and to administer anti-D Ig simultaneously.)

It is essential to administer anti-D Ig to women as soon as possible after delivery as the antibody titre against this antigen in the puerperium is low. The patient's general practitioner is also informed of her susceptibility in order that he may arrange vaccination for her at a later date. This should not be within six weeks of the administration of anti-D Ig.—We are, etc.,

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Kiddies from Living Donors

Sir,—In your leading article (18 May, p. 344), which refers to the use of live donors for kidney transplantation, emphasis is placed on the predominant use of cadaveric donors in Australia and in the United Kingdom and other European countries. While there is no doubt about the accuracy of this observation, it is not strictly true to say that in the United Kingdom kiddies from living donors are used only occasionally except in Newcastle. Kiddies from 48 live-related donors have been used at Hamner Smith, and at a conference in January 1973, which was attended by representatives of the 14 major adult living-donor dialysis centres, I quoted an incidence of 24% for live donor operations in our current practice. Many feel that cadaver kidneys are preferable, but even in the best conditions the supply and the organs are physiologically acceptable—and this implies national adoption of the concept of cerebral death—the results are not likely to be nearly as good as those achieved when living related donors are used.—I am, etc.,

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Ergotamine-induced Headaches

Sir,—We would applaud Dr. N. J. Legg (11 May, p. 331) for drawing attention to the incidence of intractable headaches in patients with a history of use of ergotamine tartrate. Since the initial publication of the experience of this condition in the Princess Margaret Migraine Clinic (formerly the City Migraine Clinic) we have had a similar experience. In a small sample of 1,000 patients referred for consultation between June 1973 and April 1974 we found that in 43 the presenting symptoms were considered to be due to excessive use of ergotamine.

Analysis of these cases shows that the condition is seen more often in women than men (F:M = 31:12) and more often in association with common migraine than with classical. In 34 patients the initial diagnosis was common migraine, in four classical migraine, and in a further six migraine was considered to suffer from headaches not due to migraine. The duration of abuse was protracted. Of the 43 patients, 19 had taken ergotamine regularly each week for more than a year, and of these 23 had taken more than 400 mg per week. Five patients had been included in our 43 patients only those who have taken more than 10 mg of ergotamine tartrate each day. This is the equivalent of 170-200 mg of the bases and nine took 30-70 mg weekly. The patients had daily headaches relieved only by further ergotamine and accompanied by nausea and general malaise, and we would emphasize that there is always some difference between the onset of the headaches and the migrainous headaches for which the patient initially sought treatment. In addition, our experience also supports the contention that if the symptoms disappear immediately or that the headaches arise once the ergotamine is actually stopped taking the ergotamine. Only five patients stated that they suffered no headache on discontinuing the ergotamine and, indeed, two patients refused to do so on account of the severity of the headache they experienced. Several patients complained of the worst headache that they had ever had when they stopped taking the ergotamine, the symptoms lasting for from one to two weeks. However, once this period was over the frequency and severity of the headache was considerably reduced.

We would welcome any suggestions which might lead to effective research into this syndrome, especially as we have no shortage of affected patients. The problem of ergotamine-induced headaches seems suitable for this condition, as the headaches improve when the ergotamine tartrate is stopped and the initial withdrawal period is over. This seems especially important as one manufacturer continues to recommend doses of ergotamine up to 24 mg/week, which, if taken regularly, would appear to be a level at which few if any patients could avoid this syndrome.—We are, etc.,

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Antibiotics and Farmers

Sir,—It seems a little hard to blame the farming community for the ineffectiveness of antibiotics in diarrhoea due to Escherichia coli, shigella, salmonellae, and other Gramnegative bacilli (leading article, 4 May, p. 235). It has been clear to many clinicians and clinical bacteriologists for some time that antibiotic agents do not have a beneficial effect on the course of the great majority of such infections, and this is unrelated to antibiotic resistance of the infecting strains. It is probably true, as you suggest, that selection of antibiotic-resistant strains is favoured by the use of antibiotics. In the individual, whether animal or human, this selection may occur if lower dosages are used because of failure to eliminate the whole of the bacterial population. I think, however, it is wrong to suggest that the lower doses themselves are the cause of resistance. My own impression is that antibiotic-resistant strains become prevalent only when conditions are suitable for spread from individual to individual, and this situation is seen in relatively closed communities such as hospital wards. More attention paid to the general epidemiological principles which prevent contagion would be more likely to be effective in reducing the spread of resistant organisms in such environments than severe restrictions of the use of antibiotics.

In the general population there is little evidence of the failure of treatment with antibiotics in proved bacterial infections. It is also probable that there are natural means for the elimination of R-factors and plasmids in the general community which balance their formation. After all, it is likely that these resistance factors and other mechanisms leading to generic change which we measure by antibiotic resistance have been around for a long time and will continue to be so. The problems created by antibiotic resistance in bacteria are small when compared with the good that has been done by...