Penicillin in leptospirosis

Sir,—The letter from Dr. R. D. Lockhart (21 July, p. 173) regarding the value of penicillin treatment in leptospirosis reminds me of a clash of opinion on this subject 17 years ago among R.A.M.C. medical specialists working in military hospitals in Malaya.

Fairburn and Semple1 reported a controlled trial of penicillin, chloramphenicol, and conservative non-antibiotic treatment among their patients, using a penicillin dosage of 600,000 units six-hourly, but failed to show a significant difference in the three groups treated. I refused to join the trial as the first patient I treated without antibiotics became so gravely ill with uremia, severe jaundice, and complete anuria for seven days that I felt it unethical to continue depriving other patients. I treated a series of 20 cases with penicillin 600,000 units four-hourly for five days2 and was able to report rapid amelioration of symptoms within 48 hours in all cases. Fourteen patients became well within 24 hours and all 20 within 48 hours. The average length of stay in hospital was only 14 days.

Mackay-Dick and Robinson3 also reported a series of 84 cases treated with 600,000 units of penicillin for seven days and they had no deaths or relapses in their group of patients.

They had no doubts regarding the efficacy of penicillin.

It might seem that the case for penicillin is still not proven in view of Fairburn and Semple’s paper, but on rereading it, the statistics are not significant and the numbers too small to justify a definite conclusion from them, it does seem that the penicillin-treated cases did better than the others. Their dosage of penicillin was lower than that used by Mackay-Dick and Robinson and myself. I still think that patients with leptospirosis should be given the benefit of the doubt and be treated vigorously with penicillin. —I am, etc.,

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Prevalence of varicose veins in Africans

Sir,—Dr. A. Rougemont (2 June, p. 547) has presented the results of an investigation undertaken in the Malai Republic in which venous varicosities were found in 10-9% of 469 African women from a tribal environment, the prevalence rate rising significantly with age. These findings are in contrast to the general belief, referred to by Mr. M. A. Hassan and others (3 March, p. 515), that the incidence of venous disorders in the people of the developing countries of Africa is low.

During a survey of arthritis in a rural Xhosa community in the Transkei, Southern Africa, we examined 297 women aged 18 and over for venous varicosity in the lower limbs. Involvement of the main long saphenous vein was present in 72%, the prevalence rising with age. The women in this survey came from two adjacent villages and were from the same ethnic stock. However, the pattern of life in one village was extremely unsophisticated, while most of the inhabitants of the other had partially adopted a more Westernized diet and life style. It is of interest that a higher proportion of women with varicose veins was encountered in the latter group (15 out of 145 as against 8 out of 152).

The incidence of 7-7% seems surprising because the number of women seeking treatment for varicose veins at the hospital servicing these villages in question is extremely low. It is noteworthy that none of the women in the survey complained of any symptoms from their varicose veins, which were well hidden by their long skirts. The fact that there is a low morbidity from varicose veins may account for the belief that the incidence of this condition in the rural African is low, whereas in actual fact it may be appreciable. —We are, etc.,

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and Robin-