Prolonged Effect of Antihypertensive Agents

Sir,—In their article on the antihypertensive effect of prazocin (11 May, 298), Dr. G. S. Stokes and Dr. M. A. Weber mention that in their experience with this drug the blood pressure, once controlled, may remain within normal limits for up to a month after stopping treatment. We have recently observed the same phenomenon after discontinuing therapy with indoramin in hypertensive patients, when normotension is maintained for control. We have also found that long periods of satisfactory blood pressure control may be achieved with this drug after several weeks, and even months, of treatment.

Weber and Stokes point out that the blood pressure may return to its original level when the drug is stopped. We have observed that after 6 weeks of treatment with indoramin the blood pressure may return to its original level within 24 hours after the drug is stopped.

We believe that the prolonged effect of prazocin and indoramin may be due to a common mechanism such as a "barostat" or "resetting" rather than a direct action of the drugs themselves.

This phenomenon complicates the design of clinical trials, as Drs. Stokes and Weber point out. It also suggests that morbidly hypertensive patients could be avoided by stopping or reducing the dose of these drugs after long periods of satisfactory blood pressure control. We are, etc.,

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Contamination of Blood Cultures from a Commercial β-Lactamase Preparations

Sir,—We wish to report an unusual source of contamination in blood cultures which led to clinical confusion in this hospital. Unfortunately we have confused other microbiologists.

Between 15 March and 19 April 1974 blood cultures from eight patients yielded a variety of oxidase-positive Gram-variable and Gram-negative bacilli with different antibiotic sensitivities. The organisms from two pairs of patients were apparently identical. In every case the bacteria were recovered only after several days' incubation and there appeared to be no possible epidemiological connection between the two pairs of patients with similar organisms.

It was then realized that all eight patients were receiving penicillin or cephalosporin therapy during these periods and that their blood was taken for culture and that "penicillinase" had therefore been added to the culture medium in each case. We had recently begun using a new "penicillinase" preparation manufactured by Whatman Biochemicals, a broad-spectrum β-lactamase with both penicillinase and cephalosporinase activity obtained from Bacillus cereus 659/H9. One batch of this product (10B) had been used for all the blood cultures and we still had three unused vials. We tested these for sterility by adding filter-stopped drops of the β-lactamase to our usual blood culture medium and subculturing after one week's incubation at 37°C. From five of the 12 cultures set up bacteria were recovered and in three cases they were identical.

We finally identified the organisms, with some difficulty, as Bacillus spp. and it became clear that the Whatman β-lactamase was the source of the contamination.

The β-lactamase preparation is tested for sterility by the manufacturers by incubation in nutrient broth for 48 hours at 37°C. When β-lactamase is added to blood culture medium it will be subjected to incubation for considerably longer than 48 hours. Whatman Biochemicals have now assured us: firstly, that they were unaware that their β-lactamase might be used in this way; and secondly, that they will now set up the precaution of filtering the β-lactamase through a 0.22-μm Millipore filter. We are, etc.,

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Minors and Contraception

Sir,—Dr. J. D. Beale (8 June, p. 563) treats the whole subject of family planning with such clarity as though Mrs. Barbara Castle had reversed or changed the policy of the previous Government. This is not so. Neither can it be said that Health Service family planning was decided upon without a great deal of discussion and debate in both Houses. Furthermore, it must be pointed out that completely free services in respect of family planning were being provided in many large cities and boroughs in Great Britain long before Mrs. Castle's announcement. These included Birmingham, Sheffield, Glasgow, and the London Boroughs of Camden and Islington, to name but a few. These local authorities had made it clear to both the Ministry of Health and the Labour Governments that they considered it a retrograde step to start levying charges where there were none before, because they knew that any sort of charge would deter the very people who needed their services most. Mrs. Castle therefore wisely extended what was the most progressive and far-sighted of the local health authorities had already done to the rest of the country.

The Family Planning Association's wholehearted support for the decision to impose no age limit on supplies of contraceptives, following appropriate consultations, is based in part on the knowledge that 95% of the young people who come to our clinics are already sexually active. Once they have become involved, further contraceptive experience increases promiscuity and un/substantiated. In fact, such evidence as does exist points the other way. A report produced in 1971 on a survey of 3,000 unwanted pregnancies showed that the more fleeting the relationship the less likely were those involved to use contraceptives. Of those in stable relationships, 85% used contraception; 15% in temporary relationships used it, and only 4% of those involved in casual sexual relationships did so.

I am, etc.,

MICHAEL SMITH Chief Medical Officer, Family Planning Association

Tests for Immigrant Doctors

Sir,—Dr. M. Sim's letter (15 June, p. 614) on tests for immigrant doctors, like his earlier article on the E.C.F.M.G. (Supplement, 8 December 1973, p. 65) has produced a number of matters which the General Medical Council, in devising its proposed mode of testing, has felt bound to take into account.

The G.M.C. concluded that the E.C.F.M.G. examination was unsuitable for British needs. It tests a doctor's power of factual recall and to some extent his comprehension of the spoken word. It does not test his ability to speak English. Further, the examination uses only multiple choice questions and thus does not test the doctor's ability to write English.

The council is able to form some idea of a doctor's basic knowledge from the information which it has about the institution where he qualified. It felt, however, that any test should be as near as possible to the questions which would be asked him in the course of medical practice in Britain. Early in 1973 the Council invited the three national organisations of doctors and National Health Service to consider whether arrangements could be made to test and assess these matters. These bodies, with the aid of linguistic experts, have made considerable progress in devising these tests. The tests will also include components designed to test the doctor's professional knowledge. The Department of Health appears favourably disposed to proposals to amend the temporary registration. The G.M.C. has indicated to the Morrison Committee that the G.M.C. would favour an end to the present system of reciprocity but, even if the Morrison Committee recommend temporary registration, the Government endorse these recommendations, legislation will be needed to accomplish the change. The formal tests and assessments