histocompatibility antigens has suggested an increased incidence in HLAs, but large-scale investigations in progress have, so far, not confirmed this result.

Emotional stress has been related to recurrent oral ulceration, though it is more likely to exacerbate the condition than to be the primary aetiological factor. A strong familial predilection has long been recognized, but a hereditary pattern has not been established.

Differential diagnosis from erosive lichen planus, erythema multiforme, pemphigus, and benign mucous membrane pemphigoid should not cause a problem; but a number of haematological disorders can mimic recurrent oral ulceration.

A few patients with macrocytic anaemia may present with lesions that may resemble any of the three types of recurrent oral ulceration. Further investigations may show vitamin B<sub>12</sub> or serum folate deficiency with confirmatory findings from bone marrow, gastric juice, and Schilling tests. Routine examination of a blood film and blood indices should be carried out on all patients referred to hospital, for iron deficiency anaemia is also seen in a few patients, though sideropenia is found more commonly. Treatment with oral iron may cause some improvement, but the ulcers tend to recur even if iron is continued for many months. A full course of intramuscular iron may induce a dramatic remission for a few months, though further injections are usually required at frequent intervals in order to suppress recurrences.

Treatment of recurrent oral ulceration has been unsatisfactory, because (as in ulcerative colitis) there is no curative measure. Topical steroids are the most helpful drugs provided they are applied during the prodromal stage of ulceration. This requires that the patient applies the steroid when the first symptoms develop, a day or two before the epithelium breaks down; during this phase lymphocytes may be reaching peak activity. The most useful preparations are 0.1% triamcinolone in Orabase, 2.5 mg tablets of hydrocortisone succinate, and 0.1 mg tablets of betamethasone 17-valerate; these drugs are usually given three to four times daily. Adrenal suppression of the adrenal cortex does not occur if the dosage is kept within reasonable limits and beta-methasone disodium phosphate is not used. Resort to systemic prednison or tetracosactrin is needed only in some patients with major aphthous ulcers, when they are used in short courses of 10 to 14 days.

Topical tetracycline is the drug of choice in the treatment of herpetiform ulcers, but it is also useful in controlling some major aphthous ulcers, though the mode of action is not clear. Mestecin capsules contain 250 mg tetracycline and 250,000 units of nystatin, which prevents development of candidiasis. The capsules are used four times daily by dissolving the contents in water and keeping the fluid in the mouth. There is a type of recurrent ulceration which appears regularly before the onset of the menstrual period; in these cases treatment with ethinyl-oestradiol 0.05-2 mg daily can suppress ulceration. In spite of expectations to the contrary, the contraceptive pill does not seem to improve these ulcers—indeed in some patients it may exacerbate them. The place for tranquilizers, such as chlordiazepoxide, in treatment is rather doubtful, and their use should be limited to patients having to cope with severe emotional problems. A number of proprietary preparations based on astringent, antiseptic, anaesthetic, and some on anti-inflammatory actions are freely available and may give transient relief.

Overall, while recurrent oral ulceration continues to present a common problem in both doctors’ and dentists’ surgeries, there is a great deal that can be done to alleviate patients’ chronic discomfort by better understanding of the differential diagnosis and management of the condition.

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4. Gunter Fischer, Jena, 188.
16. Theron, J. A., Aphthae with Special Reference to the Chronic Recurring Type of Mikulicz, Groningen, Kleine, 1959.
32. Lehner, T., Journal of Pathology and Bacteriology, 1969, 97, 481.

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Naming an Antibiotic

An entertaining and brief but fully documented review of the methods by which discoverers of antibiotics have chosen names for them is given by D. Perlman of the School of Pharmacy, University of Wisconsin. Some of the best known, and a total of about 500, have names derived from the organisms producing them, either that of the genus (penicillin, streptomycin, cephalosporins) or of the species (griseofulvin from Penicillium griseofulvum). A few, such as staphylocycin and gramicidin, denote not the source but the organisms susceptible to them. Geographical sources of the soil whence the producing organism was cultivated are denoted by lincomycin (Lincoln, Nebraska), monamycin (Miami), tylosin (Thailand). Another example, not cited by Perlman, is pimamycin, a useful antifungal antibiotic named after Pieterm-Hamazing, near which the soil yielding Streptomyces natalenis was collected. Another in the same class, nystatin, is the only antibiotic named after the institution in which it was isolated, the laboratories of the New York State Board of Health.

Some are named after people, the most famous example...
being bacitracin, Margaret Tracy being the child with a compound fracture from whose wound the producing Bacillus was isolated, where its growth was apparently contributing to overcoming septic infection. Helenine, an antibiotic of no clinical value but having an interesting action on some virus infections in mice, was so named by the late R. E. Shope after his wife Helen, because he found the mould producing it growing on the cover of a photograph of her which he was carrying while serving in the war in the Pacific. According to Perlman, three other antibiotics are named after wives: perlmycin (apparently his own), moncamycin and dorcin, saramyctin (a sulphur-containing peptide with systemic antifungal activity) after a mother-in-law, and geobricin, nancymycin, and vernamyctin after "colomy secretaries"; the references given for these three are unfortunately only to United States patents. Some oddities are peliomyctin, named after the Greek mountain Pelion; aylanin, so christened at Oxford because the producing culture was known as A5; and misin, "the only antibiotic which can be spelled backwards."

We are reminded that some antibiotics have been given four or more separate names by independent but not sole discoverers, and that rules have been formulated which should be observed when a choice is made. These require that the name be euphonious, that it should be based on chemical structure if known, or on some biological property, or on the identity of the producing organism. It is to be hoped that a new common commercial practice will not be followed in this field, here referred to as "selecting names on the basis of computer programs of euphonious syllables."


Admission for Rheumatoid Arthritis

For many years bed rest has been considered of first importance in the treatment of rheumatoid arthritis, and in any medical oral examination "rest" would be the correct answer to the question "What is the single most important item in the management of active rheumatoid arthritis?" Hilton¹ and Thomas² emphasized its importance in the last century and Duthie has repeatedly urged ³-⁵ the value of this form of treatment, in particular local rest of the joint by immobilization in splints. Kindersley and Burt⁶ noted that complete immobilization of inflamed joints for periods of one to three weeks reduced inflammation and Swanson⁷ found there was a reduction in systemic disease and improvement in wellbeing as well as local improvement.

Though bed rest has been and is assumed to improve patients with active rheumatoid arthritis proof of this is less easy to obtain. Partridge and Duthie⁸ compared the effect of complete immobilization in 34 patients with a comparable group on partial bed-rest with regular active joint movement: after one month there was no significant difference in functional capacity and range of movement in the 2 groups. Mills et al.⁹ in Boston, comparing 20 patients treated in hospital with 22 hours daily bed rest with 22 patients on a more liberal regimen, allowed home at week-ends, also found no overall difference at the end of a 10-week period, though the more active cases benefited with more complete rest. Once again, then, the value of a form of therapy generally accepted as useful has not been shown to be fully and truly proved in the hard light of careful clinical assessment.

The cost of admission to hospital being what it is proof or disproof of the value of inpatient therapy for rheumatoid arthritis is of practical interest. This Lee et al.¹ set out to do. Sixteen patients were admitted to hospital and received a modified bed-rest regimen with at least 13 hours in bed daily, while 14 were treated on an outpatient basis. All received the same oral medication—100 mg indomethacin daily by mouth in divided dosage. At the end of a month application of several objective criteria showed no significant change in the outpatient group, whereas the inpatients had evidence of statistically significant improvement, though the overall change was not dramatic and the condition was not substantially different in about half the patients. It could be argued that this was inpatient treatment but only partial rest therapy, and that more complete rest would have produced better results, but this remains unproved. There is also no record of how long after returning home the improvement lasted in those patients who benefited in hospital. Lee et al.¹ state that they believe their results justify admission to hospital of patients with severe active rheumatoid arthritis who have not benefited at home, since there is at least a 50% chance of improvement in hospital, but they do not state how long this improvement is likely to last. If it is transient, is it worth the expense to the Health Service, the use of a scarce bed, and the disorganization of home life for the patients? The answer is probably "yes" with some patients and "no" in others, for rheumatoid arthritis is a highly personal, and unpredictable disease; but Lee et al. honestly admit that their study gives no guidance as to which patients will and which will not respond to and benefit from inpatient therapy. The physician in charge of the patient with active disease who is losing ground and deteriorating on home treatment has, however, little alternative but to admit her; while there is limited evidence that rest in bed will improve her condition for any substantial length of time there is even less evidence that it often has any adverse effects.

³ Duthie, J. J. R., Practitioner, 1951, 166, 22.
⁷ Swanson, N., Canadian Medical Association Journal, 1956, 75, 257.
⁹ Lee, P., et. al., Quarterly Journal of Medicine, 1974, 4, 205.

Non-specific Genital Infection

Non-specific genital infection, though common and potentially serious, has in the past been neglected by the medical profession. Partly this may have been due to the distaste in which sexually communicable diseases were generally held. The name has been unsatisfactory (because of the lack of an identifiable cause), and the condition has often been confused with gonorrhoea through failure to apply necessary microscopic and cultural tests. The fact that it is so often asymptomatic in men and in women has added to the confusion, and the frequent absence of easily identifiable clinical characteristics