being bacitracin, Margaret Tracy being the child with a compound fracture from whose wound the producing 
*Bacillus* was isolated, where its growth was apparently con-
tributing to overcoming septic infection. Helenine, an anti-
obiotic 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: perlimycin (apparently his own), moncamycin and 
doricin, saramycetin (a sulphur-containing peptide with 
systemic antifungal activity) after a mother-in-law, and geo-
brecin, nancymycin, and vernamycin after "comely secre-
taries"; the references given for these three are unfavor-
ably only to United States patents. Some oddities are pelio-
mycin, named after the Greek mountain Pelion; ayfin, 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 prop-
erty, or on the identity of the producing organism. It is 
to be hoped that a now 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."


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**Admission for Rheumatoid Arthritis**

For many years bed rest has been considered of first im-
portance 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 cen-
tury and Duthie has repeatedly urged³ the value of this 
form of treatment, in particular local rest of the joint by im-
mobilization in splints. Kindersley and Burt⁴ noted that com-
plete immobilization of inflamed joints for periods of one to 
three weeks reduced inflammation and Swanson⁵ found there 
was a reduction in systemic disease and improvement in well-
being 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 Duthie⁶ compared the 
effect of complete immobilization in 34 patients with a com-
parable group on partial bed-rest with regular active joint 
movement: after one month there was no significant differ-
ence in functional capacity and range of movement in the 2 
groups. Mills et al.⁷ 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.⁸ 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 pro-
duced better results, but this remains unproved. There is 
also no record of how long after returning home the im-
provement lasted in those patients who benefited in hospital. 
Lee et al.⁹ state that they believe their results justify ad-
mission 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 
agree 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 
only evidence that it often has any adverse effects.


⁹ Lee, P., et al., Quarterly Journal of Medicine, 1974, 4, 205.
in women has led to ignorance of or disbelieve in its existence, particularly by gynaecologists and obstetricians, most of whom do not number the microscope among their favourite instruments.

That the disease is a force to be reckoned with is becoming abundantly clear if only on account of the increasing numbers of cases. When it was first included as a separate item in the returns from the venereal diseases clinics of England and Wales in 1954 under the heading of "non-gonococcal urethritis" it was found that the number of cases was 10,794. In 1972 the number of cases in men was 65,895— as compared with 54,974 cases of gonorrhoea in men, women, and children. A further increase occurred in 1973, though exact figures are not yet available.

Fox has recently described a study conducted in a general practice with a mainly working-class clientele in London. He investigated 325 women of whom 80% were in the third or fourth decade of life and of whom 95% were married. Ninety-eight were examined because they complained of urogenital symptoms; 227 had no symptoms and were examined in the course of routine postnatal care, for contraception, or for cervical cytological tests. Patients were excluded if they or their consorts had received systemic antibiotics within the preceding three weeks or if they were pregnant. Non-specific genital infection was diagnosed in the women if specific pathogens were absent and microscopy showed 50 or more polymorphonuclear leucocytes in several high-power fields of the cervical secretion and if this finding was confirmed by cervical cytological test. This diagnosis was made irrespective of the presence or absence of clinical evidence of cervicitis. Several patients also had microscopical evidence of urethritis. Early morning specimens of urine were obtained from consorts who had been asked to take no fluids overnight and were examined microscopically after centrifugation; if 10 or more polymorphonuclear leucocytes were seen in several high-power fields a diagnosis of urethritis was made. In all, 182 women were found to have non-specific genital infection and 54 (30%) of their consorts had evidence of infection. Of the consorts 113 women without evidence of such infection only two (1·8%) had evidence of the condition. Almost all (89%) of the 54 infected men were asymptomatic and had no previous history of urethritis. Many more of the couples in whom only one partner was affected apparently used condoms regularly than did those who shared infection, suggesting that the use of condoms might be an effective barrier to transmission of infection.

There are, thus, sound reasons for believing that non-specific genital infection is quite common in general practice, even though most infections do not present in easily recognizable form. Some general practitioners refer men with urethral discharge straight to a clinic, but many patients prefer to stay with their own doctor and many doctors believe it is right that they should do so. The method which some adopt is to give an injection of penicillin at once and refer the patient to a clinic only if his symptoms are not relieved. This may be damaging to the individual, to his sexual partner, and to the public health, and it also adds to the burdens of the venereologist. Proper care of these patients should mean accurate diagnosis, adequate treatment, satisfactory tests for cure, and the tracing of contacts, including sources of infection and those whom the patient may have infected. Accurate diagnosis requires careful clinical examination and the help of a laboratory. Treatment is not always easy. The condition does not respond to penicillin; the most effective remedies seem to be tetracycline or oxytetracycline, 250 mg by mouth every 6 hours for one to three weeks. There is some evidence that the longer duration of treatment may give better results, but little to support the view that doubling the dose is any help. During treatment the patient should abstain from alcohol and sexual intercourse. Because this condition is sometimes prone to relapse observation should, ideally, extend over three months, but it may be difficult to persuade patients to abstain from intercourse so long. During observation the patient, if a male, should be seen on at least two occasions in the early morning before the overnight urine has been passed for intrameatal smears, inspection of the urine, and microscopy of the urinary sediment. It is wise also to perform at least one microscopical examination of the prostatic fluid, for non-specific infection is the commonest cause of chronic prostatitis, often asymptomatic. Wives and sexual partners should always be examined for the disease and treated if necessary.

The management of these cases requires a good deal of work for the practitioner but is well within his compass if the case remains straightforward and he has access to laboratory help. The alarming increase in numbers of cases may make it essential that he should bear part of the burden.

1 Fox, H., British Journal of Venereal Diseases, 1974, 50, 125.
2 John, J., British Journal of Venereal Diseases, 1971, 47, 266.

Cardiovascular Disease and Peptic Ulcer

The possibility that disease in blood vessels may play a part in the aetiology of peptic ulceration has long been considered. Mucosal necrosis and ulceration have been ascribed to vascular disease in the gut wall or to submucosal haemorrhage. But in recent years some associations have been described between vascular disease and peptic ulcer or gastrointestinal bleeding which at first sight seem inexplicable or even incompatible with each other.

Patients with coronary artery disease have a somewhat greater than average frequency of peptic ulcer, particularly duodenal ulcer. A post-mortem survey showed a similar association between abdominal aortic aneurysm and peptic, especially duodenal, ulcers. Further, ischaemic heart disease was found to be extremely common in those cases. Finally, gastric ulceration has been found especially frequently in patients with radiological evidence of abdominal aortic calcification. But there are problems in determining whether these associations are real. Peptic ulceration and vascular disease are both common, and it is difficult to produce unbiased and reliable data giving exact levels of frequency. Both occur in varying grades from minimal to gross, and the decision when a vascular change becomes a disease in Western man is a matter of arbitrary judgement, for some degree of abnormality is general in adult life. Likewise the frequency with which peptic ulcer is found will depend partly on the enthusiasm of the searcher, and this can be particularly obvious where post-mortem assessment of scarring due to a healed ulcer is concerned.

If a general association between vascular disease and peptic ulcer is accepted, the basis for it is hard to define. Possible and potentially interrelated factors include a common association with smoking, a common relationship with social class, whatever that in turn might imply, and simple damage of the mucosa by a poor blood supply.