only form of uterine stimulation that I allow. If low amniotomy alone fails to effect full cervical dilatation in a reasonable time my reaction is to regard the problem as one of a mechanical impediment to adequate progress in labour, to eschew the use of oxytocics, and generally to advise caesarean section regardless of the apparent strength of the contractions. A group B streptococcus, C.S.F. were taken and benzylpenicillin and gentamicin were started. By 19 hours there was evidence of clinical improvement, serotype I a, was isolated from throat swab and blood. At discharge, aged 18 days, the baby was considered to be normal. This infant weighed 2740 g and labour lasted five hours.

The three cases occurred within a few days of each other, but serotyping demonstrated this clustering to be fortuitous. It is of interest to note that the case of late-onset meningitis was due to serotype III, which is in accord with other reported cases in the literature.1 The source of infection and the reason for the delayed onset of meningitis remain obscure. In our case the baby was healthy, of normal weight at birth, and had been at home for seven days. Serotype I (a and b) is said to be the most pathogenic subtype in the immediate neonatal period. In our two cases, one immediately after birth, the one infected with serotype II died, while the one with respiratory distress due to serotype I a survived. Though only the latter was treated, the former died less than 24 hours after birth, thus making it possible too rapidly for therapy to have had effect.

Since 1967 there have been 13 other cases of group B streptococcal infection of early onset in this hospital. Eleven of these babies died. None had evidence of meningitis. We would like to endorse Dr. Reid’s view that the group B streptococcus is an important pathogen in the neonatal period. —We are, etc.,

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Group B Streptococci in Perinatal Infections

Sir,—We note with interest Dr. T. M. S. Reid’s article (7 June, p. 533). We have recent experience of three severe perinatal infections due to group B streptococci. The infants were born by spontaneous vertex delivery, labour having been induced in each case by artificial rupture of the membranes.

The first infant was readmitted to this hospital, aged 10 weeks, with a history of sudden onset of grunting respiration and tachypnoea and was moribund two hours later. A group B streptococcus, serotype II, was isolated from cord blood and cultures. Though benzylpenicillin was administered promptly after microscopic examination of the C.S.F. deposit, the baby died 22 hours after the onset of symptoms. At birth the infant had been healthy and weighed 3400 g following a short labour—approximately 15 minutes. There was no streptococcal infection, isolated from nose, throat, or high vaginal swabs taken from the mother after the child’s death.

The second infant suffered respiratory distress within an hour of birth and died seven hours later. At post-mortem there was bilateral pulmonary consolidation, and a group B streptococcus, serotype I a, was isolated from cord blood culture. A group B streptococcus was also isolated from the mother’s high vaginal swab taken three days after delivery. This isolate was not available for serotyping. At birth the child weighed 1940 g. The duration of labour was 3 hours.

The third infant was noted to be limp, with shallow breathing, five hours after birth and by 12 hours had deteriorated markedly, with tachypnoea and cyanosis. At this stage, C.S.F. were taken and benzylpenicillin and gentamicin were started. By 19 hours there was evidence of clinical improvement, serotype I a, was isolated from throat swab and blood. At discharge, aged 18 days, the baby was considered to be normal. This infant weighed 2740 g and labour lasted five hours.

Agency Nurses

Sir,—For the first time in the history of the Health Service a Secretary of State is prepared to risk the welfare of patients in order to achieve an administrative objective—an objective, moreover, which is neither realistic nor economical. In a circular addressed to regional and area health authorities and boards of governors she is calling for the elimination of the use of agency nurses from the N.H.S., though she acknowledges the value of the contribution made by agency nurses and in spite of the fact that she “appreciates that a short term national campaign is essential in order to achieve the longer term aim of a more stable nursing force.”

Even if her objective were likely to be achieved by such elimination this could not justify short-term action to patients. The fact is, however, that the elimination of agency nurses would inflict long-term harm on the N.H.S. There are two factors which seem to be completely ignored by the Secretary of State: (1) it will be no cheaper to run the Health Service without agency nurses. This has been admitted time and time again in answers to parliamentary questions by Ministers in successive Governments. (2) If agency nurses cannot nurse through their agencies, over half will leave nursing completely. This fact was established by a survey6 carried out by this organization in 1974 and reflects the views of the agency nurses themselves.

Lastly, the Secretary of State suggests that, while it is wrong to use nurses from agencies, it is quite proper to use nurses from nurses’ banks set up by the hospitals themselves. All the alleged incoherencies of agency nursing are equally present with nurses supplied by nurses’ banks and the only difference between the two is that one is operated by nurses in private enterprise whereas the other is operated by nurses in public service. Nurses’ agencies have no quarrel with nurses’ banks; see any widespread extension of this system as an inefficient method of replacing the services that agencies already offer.

My purpose in writing this letter to you is to alert your readers to the fact that as of 1975, prepare to allow N.H.S. patients to suffer rather than accept a system of private enterprise which is controlled by law and which has worked satisfactorily for many years.—I am, etc.,

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Anabolic Steroids in Athletics

Sir,—Dr. D. L. J. Freed and others (31 May, p. 471) showed that performance improved significantly (range 0-15 %) among weightlifters taking anabolic steroids; their body weight also rose by about 3 kg.

The increase in weightlifting capability in the heavier weight groupings. The figure shows the increase in the weightlifting capability in the heavier weight groupings. The gain in performance attributable to steroids has to be matched with the initial weight and the weight gains; for the same weight gain the lighter weights have to perform far better than the heavier weights.

The ethical considerations as to the use of anabolic steroids are obvious. One must ask the question, what is the purpose of an athlete using steroids to gain an unfair advantage need reviewing. The real advantage of using anabolic steroids from a performance point of view is to improve the strength (in the shorter, shot and running events). The javelin throw involves an initial run and the extra weight will be a handicap to the thrower. The throwing and running events are contested among the tall, whereas even the six-footer (183 cm) is short (range of eight finalists in short put, Munich Olympics 1972, 186-202 cm; range of winning running team, 183-196 cm (excepting coswain who was of average height, 175 cm)). A tall competitor has two