

of bronchitis. But in fact the authors produce no justification for this practice.

If we consider objectively what we are trying to do, it becomes obvious that to treat acute bronchitis, or an exacerbation of chronic bronchitis, by giving a set "course" of antibiotic, whether of five or any other number of days, is completely illogical. Our object is to eliminate the infection; therefore the antibiotic must not be stopped until there is good evidence that this has been achieved, and it is impossible to predict how long this will take. The chosen drug should be prescribed in adequate dosage for a reasonable time, say one week; but the doctor must arrange to see the patient again at the end of this period. He can then decide on clinical grounds (control of symptoms, fever, and character of sputum) whether to maintain, reduce or discontinue the drug. Concerning dosage; recent work suggests that the customary 250 mg. q.d.s. of tetracycline or ampicillin is often insufficient in the early stages of an infection, and that double this dose should be given.

If we could forget the "five-day course" and get back to these basic principles (adequate dosage of antibiotic and observation until the desired effect has been obtained), there is no doubt that many patients would be spared a great deal of prolonged illness and hospital treatment.—I am, etc.,

A. F. FOSTER-CARTER.

Brompton Hospital,
Frimley Branch,
Surrey.

REFERENCE

- ¹ *British National Formulary*, p. 93. London, B.M.A. and the Pharmaceutical Society of Great Britain.

Deaths from Appendicitis

SIR,—In congratulating Dr. H. G. Pledger and Mr. R. Buchan on their informative, convincing, and timely paper on deaths in children with acute appendicitis (22 November, p. 466) I would like to make three comments.

Firstly, I believe that the figures they derive from their analysis of the Registrar General's statistics are probably an underestimate. The accuracy of death certification leaves much to be desired, whether in domiciliary or hospital practice. I feel that if search was made under some additional code numbers—for example, 576 (general peritonitis), the total annual mortality rate from acute appendicitis in children would prove greater than they report.

Secondly, although delay in diagnosis may explain only a small proportion of deaths in the series investigated, this factor remains significant. I have stressed the point elsewhere¹ that in most series of children under the age of 5 with acute appendicitis nearly 50% are found to have already perforated by the time operation is done. In the paper under discussion the very high incidence of "appendicitis with peritonitis" emphasizes the problem. Unfortunately it appears that in small children appendicitis progresses very rapidly and that prior to perforation the signs and symptoms may be extremely difficult to assess. Whether this has relation to the high proportion of lymphoid tissue in the child's appendix or to some other factor, perhaps viral infection, remains unknown. Without new developments in technique in diagnosis "good training and a constant suspicion of acute appendicitis" cannot produce more than marginal improvement.

Finally, although it is hinted that there is a considerable difference in the mortality rates according to the type of hospital, it is perhaps a pity that more definite figures could not be given. If, as seems all too likely, the mortality rates are high in relatively small hospitals where children with acute abdominal conditions are managed only sporadically, and if, in contrast, results are better where it is possible to have the benefits of skilled paediatric care, medical and nursing, then this supports the implications of the recent Bonham-Carter Report.² Emergency surgery on small children is best carried out either in large special hospitals for children or in district hospitals where there is a viable paediatric unit, which can offer all the assistance necessary in these difficult cases.—I am, etc.,

Liverpool 1.

JOHN SHEPHERD.

REFERENCES

- ¹ Shepherd, J. A., *Surgery of the Acute Abdomen*, 1968, 2nd ed., p. 245. Edinburgh, Livingstone.
² Central Health Services Council, *The Functions of the District Hospital*, 1969. London, H.M.S.O.

Spinal Injuries

SIR,—In his article on spinal injuries and fractures (15 November, p. 414) Mr. J. Ashworth rightly draws attention to the importance of careful first aid treatment. However, he makes certain statements which we feel should not pass without comment.

He states that "Injuries to the spine may be classified as stable or unstable." We feel that this classification is too simplified and that varied degrees of stability may be encountered. Immediately afterwards he comments that "it is invariably in the unstable injuries that damage to the cord occurs." This is not confirmed by our experience because, not infrequently, permanent paralysis is caused by very simple crush fractures, and indeed in some cases of traumatic paraplegia, particularly in children, there is no x-ray evidence of bony injury or dislocation.

However, the statement to which the greatest exception must be taken is that under the heading of "Treatment," where Mr. Ashworth claims that "With the exception of injuries in the cervical region, any neurological damage usually occurs at the time of impact. Hence there is nothing that can be done at the site of the accident that will have any effect on the ultimate prognosis." This is incorrect and misleading, and could well result in serious mismanagement of patients by ambulance personnel and others who may read the article. In our own experience it is not unusual to obtain a clear history of the onset of the neurological damage during transport, or indeed sometimes in hospital, and this may occur with dorsal and lumbar injuries as well as with cervical injuries. A recent example was a woman with a mid-thoracic fracture without neurological damage, who was treated by being sat upright in bed and within some minutes developed a paraplegia at T.5 (albeit sensory incomplete), which failed to recover.—We are, etc.,

J. J. WALSH.
H. L. FRANKEL.
G. M. HYSLOP.
D. O. HANCOCK.

National Spinal Injuries Centre,
Stoke Mandeville Hospital,
Aylesbury, Bucks.

Pregnancy and Chlormadinone Acetate

SIR,—I should like to comment on the advertisement for Verton (chlormadinone acetate 0.5 mg.) (22 November, pp. xix and xx). I am a little concerned that the risk of pregnancy should be more clearly stated. Verton is said to be "more reliable than mechanical methods of contraception," and doctors are requested to report any pregnancies occurring to the Dunlop Committee on Safety of Drugs. It is also suggested that Verton "is useful for all those who are unreliable at taking their tablets because of the simplicity of everyday medication."

Perhaps potential prescribers would be interested to know of the latest results in the trial of chlormadinone acetate 0.5 mg. organized by the Council for the Investigation of Fertility Control at various centres throughout this country. Two hundred and twenty-three women have been enrolled and 2,518 cycles have been completed. Twenty pregnancies have occurred, and of these only five women admitted omitting tablets. One of these women omitted the 12th, 14th, and 15th tablets in the cycle and conception followed.

When pregnancy is definitely contraindicated for medical or social reasons I would suggest that this type of contraception is not the method of choice.—I am, etc.,

CHRISTINE BUTLER,

Medical Assistant,
Council for the Investigation of
Fertility Control.
London W.1.

Intraocular Lenses

SIR,—In his typically erudite and witty account of "Spectacles in Evolution" (*The Times*, 4 November, p. 16), Mr. P. D. Trevor-Roper said: "The correcting lens can even be slipped into the eyeball itself, although the operation has generally been abandoned because the eye is often damaged irreparably in the process."

My distinguished colleague is entitled to his views, but they are not necessarily those of the rest of the ophthalmic profession. Intraocular lenses came into being about 20 years ago, with the posterior chamber lens used by Harold Ridley for the correction of aphakia. Then followed a period of frenzied activity, in which many different types of intraocular lens implants were used and many complications arose. Understandably, public opinion went against these devices and Mr. Trevor-Roper's remark, if made 10 years ago, would probably have been justified. But since then there have been various developments which suggest that such a view is now out of date. For some years now there has existed the "Intra-Ocular Implant Club," an association of like-minded eye surgeons in many different countries who regularly use such lens implants in the best interests of their patients. There are at least two British surgeons each with a personal series approaching the 1,000 mark. One of the principal implant manufacturers is British; they regularly dispatch substantial numbers to various parts of the world; they report a steady increase in demand for them.

As recently as June last the section of ophthalmology of the Royal Society of Medicine devoted an entire session to the consideration of the late results of intraocular implants. Patients (some with