criticised usage (though quite impartially, being unaware, I think, of my advocacy of it); and he himself supports my second, Fowler- and Bye-approved, usage. As regards the first and criticised usage Sir Ernest sits uneasily on the fence but gives as his final word that it had been defended also, because of the frequent inelegance of the alternative, by no less a person than Onions. The point concerning inelegance is one that is mentioned and illustrated by Dr Bye, though it does not deter him from insistence on the inflexibility of his gerund rule. The flexible Onions in question is, of course, the great Onions, the magisterial Onions of the *Oxford English Dictionary*; a figure, like Jespersen, greater even than Fowler; and he wrote: "If this rule [the one Dr Bye insists upon] were pressed, we should have to say: 'His premature death prevented *anything's coming* of the scheme,' which can hardly be called English." I like to write what can be called English; and usually succeed, especially when I am trying to write French.

With scholars of the calibre of Onions and Jespersen defending my disputed usage, Fowler in disarray, Gowers unsure, and the usage practised by two even greater men in Swift and Shaw (two of my blood-compatriots, from whom I got much, including perhaps my gerunds)—with all this going for me I am happy not to dilate further upon Dr Bye's stricture. He says he awaits with interest the exposure of his own solecisms. I noticed three in his letter. However, this is the season of good will and I will not descend to minute particulars. Anyway, I have made many errors myself, though what he identified in this instance as errors were, in fact, examples of good common English usage.

JOHN S BRADSHAW

Hereford

¹ Fowler, H W, *A Dictionary of Modern English Usage*, 2nd edn, revised E Gowers, p 215. London, Oxford University Press, 1965.

*.*This correspondence is now closed.—ED, BMJ.

Prescribe British

SIR,—Dr J R T Gabriel's plea (11 December, p 1448) to doctors to prescribe British-made products of British companies is ill-judged. The large majority of drugs prescribed in Britain are manufactured here, whether by British-owned or foreign-owned companies. Furthermore, not all products sold by British companies were discovered, or are made, in Britain, while many products sold here by foreign-owned companies have been discovered here by their respective UK research organisations.

These observations merely underline the international nature of the pharmaceutical industry, which is a major advantage for doctors and patients alike in view of the enormous and ever-increasing investment necessary to discover and develop new drugs. The very favourable balance of trade created by the pharmaceutical industry (£273m in 1975 and 7% of the positive balance of trade of the entire UK manufacturing industry) arises from foreign-owned as well as UK-owned companies.

Any support for Dr Gabriel's rather chauvinistic proposal would have the effect

of seriously reducing the range of products available for use and discouraging investment in UK subsidiaries of foreign-owned companies. This in turn would have an adverse effect on employment, on future discoveries, and on our positive balance of trade.

R B ARNOLD

Association of the British
Pharmaceutical Industry,
London W1

Chiropody services

SIR,—I was surprised to read the statement in Dr Mabel Haigh's letter (11 December, p 1449) that chiropodists should accept "necessary guidance from a patient's general practitioner."

I entirely agree that there should be a closer working relationship between the members of the different medical professions, including chiropodists as well as doctors, and that the patient's whole bodily health needs to be taken into account. Members of the chiropody profession have always had the right to diagnose and treat patients directly without medical reference, whether in private practice or in the NHS. Members of this society are trained to recognise those underlying medical or surgical conditions which may require reference to a consultant for treatment. I would hope that general practitioners would also recognise those conditions of the feet and nails which are best treated by a chiropodist.

My society is, however, concerned that as the law stands unregistered chiropodists, who may not be adequately trained and are not under the jurisdiction of a professional organisation or of a registering body, may treat patients privately; in the Health Service only State registered chiropodists may be employed. Therefore it is urging an amendment to the Professions Supplementary to Medicine Act to close the profession of chiropody, which will give the public the protection which I think that Dr Haigh is seeking. I hope that the society will have the support of the wider medical profession in seeking this amendment to the existing law.

G C JENKINS

Secretary,
Society of Chiropodists

London W1

Effect of oral contraceptives on plasma testosterone concentration

SIR,—We have recently had the opportunity to study the effect of the oral contraceptive Minilyn (ethinyloestradiol 50 µg + lynoestrenol 2.5 mg) on the plasma testosterone concentration in nine hirsute patients. Multiple samples were obtained from each patient both before and during this oral contraceptive therapy and the mean value before and during treatment calculated for each patient (patient mean values). The results are shown in the table; there was a significant fall ($P < 0.001$) in the plasma testosterone concentration during oral contraceptive therapy with Minilyn.

In addition one patient was studied who was treated initially with Minovlar (ethinyloestradiol 50 µg + norethisterone acetate 1 mg) and following this with Minilyn. The mean plasma testosterone value during treatment with Minovlar was 0.97 nmol/l (281 pg/ml) and

Effect of treatment with Minilyn on plasma testosterone concentration

	Plasma testosterone (nmol/l)		
	Mean of patient mean values	SD	Range
Before treatment	2.09	0.49	1.27-2.95
During treatment	1.27	0.34	0.64-1.80

Conversion: SI to traditional units—Testosterone: 1 nmol/l $\approx$ 290 pg/ml.

during treatment with Minilyn 0.45 nmol/l (142 pg/ml). The patient received no other medication during the period of study.

The discrepancy between our findings and those of Dr J M Kjeld and others (4 December, p 1354) may be explained by the fact either that (1) hirsute patients behave differently when treated with oral contraceptives or that (2) the progestogen component of the oral contraceptive influences the changes in serum testosterone concentration. Our findings in the one patient treated with two different oral contraceptives would lend support to this latter theory.

We therefore suggest that future studies of the effect of oral contraceptives on plasma steroid concentrations should pay specific attention to the contraceptive combination being used because of the probable variation in response to different preparations.

MARGARET C K BROWNING

JOHN ANDERSON

University Departments of Biochemical
Medicine and Dermatology,
Ninewells Hospital and Medical School,
Dundee

Contraceptive dynamism

SIR,—Your leading article on this subject (11 December, p 1405) leads me to ask why it is only in Britain that medical orthodoxy requires that no mention be made of natural variation in female fertility and its role in avoiding pregnancy. The last 10 days of every ovulatory cycle are naturally infertile. Women can learn to identify ovulation by temperature graphing and by observation of ovulation signs and symptoms, particularly mucus production from the uterine cervix.

It is accepted that natural methods of identifying the fertile and infertile phases of the female cycle require personal maturity and responsible use of sexuality, and this is likely only within marriage. It is a reasonable presumption that the great majority of acts of intercourse do take place within marriage, and the positive human values involved in using natural methods of avoiding pregnancy are admirable.

Natural methods impose constraints and can be criticised if the pregnancy rate is the only criterion used in considering contraception, but this surely does not justify a leading article which makes no mention of the natural variation in female fertility.

JAMES MCGARRY

Glasgow

Spontaneous pneumothorax

SIR,—Thoracoscopy is now rarely performed. Twenty-five years ago the pleural cavity and

lung surface were frequently inspected during the procedure of pleural adhesion section by cautery, used to permit free lung deflation during artificial pneumothorax for pulmonary tuberculosis. Thus as a young consultant physician working in a thoracic surgical unit one had ample opportunity to inspect the visceral pleura and to note differing appearances. Because of this facility with the thoracoscope we took the opportunity of inspecting the pleura during chemical pleurodesis for recurrent "idiopathic" spontaneous pneumothorax. We recognised, as does your leading article (11 December, p 1407), that this condition is most common in tall "lanky" young men, but we observed in addition that these patients have a specially thin, transparent visceral pleura studded with dozens or even hundreds of surface blebs. We had no doubt that each of these represented herniation of a group of alveolar sacs covered by paper-thin pleura. It seemed clear to us that any one of these minute hernial blisters might burst spontaneously and that the degree of lung deflation would be proportionate to the size of the resultant puncture hole.

Why tall, thin young men have a thin pleura is open to conjecture, but your observation that spontaneous pneumothorax is found in Marfan's syndrome may be relevant.

THOMAS SEMPLE

Victoria Infirmary,
Glasgow

Retinal vein occlusion

SIR,—I was interested in the up-to-date approach to this subject in your leading article (11 December, p 1406). You correctly infer (without mentioning by name) that this is a "stasis" retinopathy in which complete thrombosis of the venous lumen is unusual and in which visual recovery is more related to retinal capillary damage than to the extent of haemorrhage.

However, under management you have failed to mention the value of an intravenous plasma volume expander such as dextran 70, which is useful in states of capillary anoxia and which may have a dramatic effect when given within the first 24 h of visual loss.

S P B PERCIVAL

Scarborough Hospital,
Scarborough,
N Yorks

Timing of cervical smears

SIR,—I am pleased that the DHSS has at last made some effort at clarification of the payment of fees to general practitioners for cervical smears, but as one who has had some experience in gynaecology it gives me much distress that an attempt is still being made to discourage smears at any greater frequency than five years. This is particularly anomalous when I think back to the 24-year-old whom I saw die of carcinoma of the cervix and to the many young women under 35, and of low parity, in whom I have diagnosed carcinoma-in-situ or invasive carcinoma by the use of frequent smears. Indeed, it is policy at the hospital where I work as clinical assistant and at the family planning clinics I do to repeat all routine smears at 18 months' interval.

This policy of the DHSS is therefore designed to encourage me to have a double

standard according to whether I work in my practice or not. Naturally I will not drop my standards and will continue to take smears at 18 months' interval and be paid for about one in four. Many other practitioners will of course not adopt this policy, and in spite of statistics on the occurrence of carcinoma-in-situ I wonder whether this is in the best interests of the health of the country?

Would it not be possible to pay for all smears which a GP considers worth taking, thereby doing away with one clerk whose job must be to vet the claim forms submitted? Surely no GP is going to take smears at ludicrously frequent intervals just to get a fee of £2.30?

RICHARD SIMMONS

Bexley, Kent

Integrated approach to asthma

SIR,—It is ironic that in the same issue of the *BMJ* as *Integrated Medicine: The Human Approach* is so favourably reviewed (4 December, p 1394) there should be published a letter from Dr H W Fladée (p 1383) criticising you for publishing an article which emphasises the importance of such an approach in childhood asthma (23 October, p 1003).

Dr Fladée suggests that social circumstances are irrelevant in asthma and thus "all the talk about the family is so much verbiage." The influence of sociopathology in childhood asthma has been very clearly demonstrated by Pinkerton,¹ while there have been two recent comprehensive reviews of all the evidence for the significance of social factors.^{2,3} Evidence is now also available demonstrating the effectiveness of a combined medical and psychosocial approach to the problem.⁴

To dismiss so forcibly social aspects as verbiage reveals, at very best, an unfortunate ignorance of the literature on the subject.

BRYAN LASK

Department of Psychological Medicine
Hospital for Sick Children,
Great Ormond Street,
London WC1

¹ Pinkerton, P, *Psychotherapy and Psychosomatics*, 1970, **18**, 231.

² Mattson, A, *Pediatric Clinics of North America*, 1975, **22**, 77.

³ Pilling, D, *The Child with Asthma*. Slough, NFER Publishing Co, 1975.

⁴ Liebman, R, Minuchin, S, and Baker, L, *American Journal of Psychiatry*, 1974, **131**, 535.

Management of appendicitis

SIR,—Mr A W Clark (9 October, p 881) reports that of 28 patients with a gangrenous or perforated appendix, 18 developed post-operative infections whether antibiotics were used or not. His suggestion that delayed primary suture of the wound will reduce sepsis rates in those cases with a high risk of post-operative infection is intriguing. If, as he suggests, the wound is closed at four days the patient may need a second anaesthetic, discharge from hospital will certainly be delayed, and the final scar may well be unsightly. Fraser-Moodie¹ carried out a trial of delayed primary suture in six patients with suppurative appendicitis and reported that five of these patients developed severe wound infections which took from one to three months to heal.

Mr Clark's letter makes one suspect that few surgeons at King's College Hospital accept

that the most important pathogen in the genesis of infection after appendicectomy is *Bacteroides fragilis*. These anaerobic organisms are not sensitive to the antibiotics most frequently used for patients with a gangrenous or perforated appendix—namely, penicillin and streptomycin,² ampicillin,³ and penicillin and gentamicin.⁴

Leigh⁵ and Willis⁶ have demonstrated a marked fall in sepsis rates when appropriate antibiotics such as lincomycin and metronidazole are used. At this hospital we have recently conducted two trials using metronidazole alone for the prevention of sepsis after appendicectomy.^{6,7} In these two trials there were 27 patients whose appendix was gangrenous or perforated and in these patients there were six infections. These infections were minor or superficial and no patient received further chemotherapy. This group of 27 patients, all admitted with severe intraperitoneal infection, stayed in hospital between three and 15 (mean 6.7) days.

W M MEE

Luton and Dunstable Hospital,
Luton, Beds

¹ Fraser-Moodie, A, *Journal of the Royal College of Surgeons of Edinburgh*, 1974, **19**, 121.

² Longland, C J, et al, *British Journal of Surgery*, 1971, **58**, 117.

³ Leigh, D A, *British Journal of Surgery*, 1975, **62**, 375.

⁴ Lari, J, et al, *British Journal of Surgery*, 1976, **63**, 643.

⁵ Leigh, D A, *Journal of Clinical Pathology*, 1974, **27**, 997.

⁶ Willis, A T, et al, *British Medical Journal*, 1976, **1**, 318.

⁷ To be published.

Hip fractures up to date?

SIR,—In his article concerning current practice in the management of patients with hip fractures (11 December, p 1429) Mr P A Ring states correctly that pulmonary embolism is the commonest postoperative complication. In fact, approximately one patient out of every 10 will die from pulmonary embolism within three months of injury unless an effective prophylactic measure is adopted.^{1,2} However, he states that "an elastic supporting stocking to encourage venous return, early mobilisation, and keeping the legs horizontal when sitting are probably as important as any of the medical measures of prophylaxis." This viewpoint is indefensible, for there is no evidence that such simple physical measures can protect these high-risk patients from pulmonary embolism.

Moreover, with the exception of anticoagulation there is no clearcut evidence that any of the currently available prophylactic methods are of value in elderly patients with fractures of the femoral neck. Unfortunately, Mr Ring is correct when he states that prophylactic oral anticoagulation has not gained wide acceptance. According to our survey³ only 3% of orthopaedic surgeons routinely use this measure in patients with hip fractures despite the weight of evidence favouring its use.^{1,2} We accept that prophylactic anticoagulation is tedious and not without complications, but it will prevent pulmonary embolism.

G KEITH MORRIS

J R A MITCHELL

University Department of Medicine,
General Hospital,
Nottingham

¹ Sevitt, S, and Gallagher, N G, *Lancet*, 1959, **2**, 981.

² Morris, G K, and Mitchell, J R A, *Lancet*, 1976, **2**, 869.

³ Morris, G K, and Mitchell, J R A, *Lancet*, 1976, **2**, 867.