the removal of irrelevant pack inserts should be as much a part of the supply of medication as ensuring the clear and concise labelling of the product for the patient.

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Streptococcus bovis endocarditis with carcinoma of the colon

SIR,—With reference to Dr Celia Oakley's excellent article on endocarditis (12 August, p 489) we would like to comment on the association of *Streptococcus bovis* endocarditis with carcinoma of the colon. *Str bovis* is a non-enterococcus and is sensitive to penicillin and streptomycin. This association has drawn a lot of attention recently in North America.

Klein *et al*¹ reported the increased incidence of positive faecal cultures for *Str bovis* in patients with colonic carcinoma. Since then several other case reports have appeared confirming this association. The recent literature emphasises the importance of differentiating group D streptococci by species in patients with infective endocarditis and the need for investigating patients with *Str bovis* endocarditis for bowel carcinoma.²

We hope this letter will heighten the clinical awareness of this "syndrome" in the UK.

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¹ Klein, R S, *et al*, *New England Journal of Medicine*, 1977, **297**, 800.
² Levy, B S, *et al*, *New England Journal of Medicine*, 1978, **298**, 527.

Link between hepatoma and hepatitis B

SIR,—In your leading article on this subject (9 September, p 718) you state that HBs antigenaemia is more common in hepatoma secondary to cirrhosis than in hepatoma unrelated to cirrhosis. For sub-Saharan Africa, where hepatoma is so common, the evidence for this is tenuous—patients present late, often with huge tumours which have all but replaced normal liver tissue, and neither needle biopsy nor post-mortem study may reveal the pre-existing cirrhosis. An under-estimate of the prevalence of cirrhosis in hepatoma is therefore likely. Furthermore, you have ignored HBs antigenaemia in cirrhosis itself. A number of studies have shown that in cirrhosis antigenaemia occurs as frequently as, or more frequently than, in hepatoma. No African studies I know have shown that the prognosis of these HBs-positive cirrhotics is worse than the HBs-negative cirrhotics nor that the positive patients are more likely to develop an HBs-associated hepatoma.

The studies of Larouze *et al*¹ suggest that maternal transmission of hepatitis B virus (HBV) may be of importance in the development of hepatoma but is not sufficient by itself. Since a cocarcinogen (? environmental) is required, prevention of hepatoma would more logically be directed to the elimination of this, since not all hepatomas are HBV-related. The costs of HBV vaccine development, coupled with the well-known problems

of immunisation in the tropics (where most hepatomas are found) make it unlikely that an effective vaccination campaign could be mounted. Epidemiologically, the mycotoxins remain important probable co-carcinogens: intervention studies based on lowering mycotoxin contamination through improved storage of cereals will probably prove substantially cheaper than vaccination and may well provide an answer to hepatoma within the next 20 years.

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¹ Larouze B, *et al*, *Lancet*, 1976, **2**, 534.

Paraldehyde and plastic syringes

SIR,—In response to a query last year all locally available makes of disposable syringe and needle were closely examined after exposure to paraldehyde for several minutes. All needle hubs tested were unchanged, but of the five makes of syringe tested the clear plastic Gillette Sabre and Steriseal showed immediate signs of damage and the piston stuck firmly to the barrel within 2½ minutes. Becton Dickinson, Brunswick, and Everest Medical syringes, which are of a more opaque plastic, appeared undamaged within five minutes. Therefore we do not agree with the statement made by Dr D P Addy (16 September, p 81) that plastic syringes may be used provided the paraldehyde is drawn up immediately before injection. In practice it would take some time to draw up the required volume, identify a suitable site, keep the child still, and insert quite a large volume of fluid.

As syringe packs carry a warning against use with paraldehyde and manufacturers may change their specifications without notice, doctors will need to check their plastic syringes carefully to ensure that they will actually be able to make an injection of paraldehyde in an emergency.

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Interaction of warfarin with antacid constituents

SIR,—It has been suggested that antacids may affect warfarin absorption from the gastrointestinal tract¹; in clinical studies by other authors^{2,3} no change in warfarin absorption has been reported during concomitant administration with magnesium and aluminium hydroxides. A report by Talbot and Meade,⁴ however, implicated dimethicone, a constituent of certain cooking oils, as causing decreased absorption of warfarin in several patients. Activated dimethicone is now used extensively as an antifoaming agent in antacid preparations. Consequently it was thought important to determine if, and to what extent, an interaction occurs between antacid constituents (including activated dimethicone) and warfarin and between kaolin (an adsorbent) and warfarin. The study employed an in-vitro technique which has already been clinically evaluated with the tetracycline-metal ion⁵ and the digoxin-antacid⁶ interactions.

Effects of antacid constituents on warfarin absorption in vitro

Antacid constituent	Percentage decreased absorption of warfarin
Aqueous emulsion of activated dimethicone (35%)	0
Bismuth carbonate	6.9
Kaolin	0
Magnesium trisilicate	19.4

The results (see table) indicate that for clinically equivalent doses of antacid constituent and warfarin sodium there was a small decrease in warfarin absorption when in combination with magnesium trisilicate and bismuth carbonate; however, kaolin and activated dimethicone showed no decreased absorption. These findings suggest that warfarin absorption kinetics may be affected by concomitant administration of certain antacid constituents. We would suggest that the patient should be made aware of this.

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¹ Hussar, D, *Journal of the American Pharmaceutical Association*, 1970, **10**, 78.
² Robinson, D S, Benjamin, D M, and McCormack, J J, *Clinical Pharmacology and Therapeutics*, 1971, **12**, 491.
³ Ambre, J J, and Fischer, L J, *Clinical Pharmacology and Therapeutics*, 1973, **14**, 231.
⁴ Talbot, J M, and Meade, B W, *Lancet*, 1971, **1**, 1292.
⁵ D'Arcy, P F, Muhyiddin, H A, and McElnay, J C, *Journal of Pharmacy and Pharmacology*, 1976, **28**, 33P.
⁶ McElnay, J C, *et al*, *British Medical Journal*, 1978, **1**, 1554.

Absence of interaction of digoxin with antacids under clinical conditions

SIR,—We have read with interest the letter from Mr J C McElnay, and others (10 June, p 1554) concerning the interaction of digoxin with antacids. It substantiates the earlier in-vitro study of Khalil,¹ who noted a high level of adsorption of digoxin by magnesium trisilicate. Brown and Juhl² demonstrated in healthy volunteers what they claimed to be a severe reduction (30%) in the absorption of oral digoxin by magnesium trisilicate, although they studied single large doses (750 µg digoxin and 2.8 g magnesium trisilicate).

In a preliminary study we have investigated the effects of smaller amounts of two antacid preparations on the absorption of more normal doses of digoxin (250–500 µg) in four patients on chronic medication. Bioavailability was estimated by the quantity of digoxin excreted in the urine during the final 24 h of three seven-day periods. The seven-day drug administration schedules were digoxin alone (schedule A), digoxin with aluminium hydroxide mixture BPC 10 ml thrice daily (schedule B), and oral digoxin with magnesium trisilicate mixture BPC 10 ml thrice daily (schedule C). Patients thus acted as their own controls in a crossover fashion. Neither antacid significantly reduced the bioavailability of these oral doses of digoxin and none of the patients showed any reduction in the control of their symptoms.

The investigation would suggest that interaction between digoxin and magnesium trisilicate may not be significant in most

clinical situations. The possibility of an interaction occurring could be further reduced if the antacid preparations are given, as is usually recommended, between meals and the digoxin as a single daily dose before or with food.

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- ¹ Khalil, S A H, *Journal of Pharmacy and Pharmacology*, 1974, **26**, 961.
² Brown, D D, and John, R P, *New England Journal of Medicine*, 1976, **295**, 1034.

Management of dermatomyositis

SIR,—The management of dermatomyositis in patients over the age of 40 (Any Questions? 30 September, p 938) should include a search for occult carcinoma. Dermatomyositis in this age group is frequently associated with anti-tumour antibodies either cross-reacting with striated muscle and skin elements¹ or reacting at these sites with tumour antigen released into the circulation.² Removal of the tumour (oesophageal carcinoma may be preceded by a long history of chronic inflammation) often results in remission of dermatomyositis.

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- ¹ Alexander, S, and Forman, L, *British Journal of Dermatology*, 1968, **80**, 86.
² Turk, J L, *Immunology in Clinical Medicine*. London, Heinemann, 1972.

*Our expert writes: "The association of neoplasms with dermatomyositis is well known. Described 25 years ago,¹ it is featured in standard textbooks.² Thus the comment in the question that the man was in excellent health was taken to imply that an associated neoplasm was unlikely. It is, however, of course correct to consider this possibility both at the onset of dermatomyositis and at follow-up visits."—Ed, *BMJ*.

- ¹ Curtis, A C, Blaylock, H C, and Herrell, E R, *Journal of the American Medical Association*, 1952, **150**, 844.
² Hart, F D, in *Textbook of the Rheumatic Diseases*, ed W S C Copeman, 4th edn. Edinburgh, Livingstone, 1970.

Pricing the consultants' contract

SIR,—At the meeting of the Central Committee for Hospital Medical Services on 21 September (30 September, p 974) it was made clear that the new consultant contract was in the doldrums owing to the refusal of the Review Body to price it except as part of an April 1979 review. (The refusal to produce an interim report indicates that it has not been swayed from its expressed intention¹ to regard the pricing of the new contract as a mere redistribution exercise and not as a genuine attempt to place a fair value on its various elements.)

Worse, it was stated that the employing authorities anticipated that a minimum of six months would be required for implementation from the time of acceptance of the priced contract. Why it should take so long was not explained; but in an attempt to expedite

implementation it was suggested that the employing authorities should be empowered to approach consultants about their intentions with regard to the new contract and for an estimate of the number of notional half-days (NHDs) they would require. The previous review of consultants' hours of work² was dismissed as inaccurate and likely to lead the Review Body to undervalue the NHD—but how the new survey would be made more accurate and how it would avoid the latter pitfall was unclear. Indeed, it seems dubious that the proposed information could expedite implementation. Fortunately the CCHMS rejected the idea, but a compromise was reached leaving the executive free to explore the possibility of conducting its own inquiry.

The executive should abandon any notion of so doing and concentrate on the main problem of the contract: to have it adequately priced as soon as possible. It must keep in mind that the pricing will be unacceptable unless the salary scales for the existing whole-time contract relate only to the 10 NHDs of the basic new contract. As there is no hope that the Review Body will do this (it may botch together some complicated deal which will still be unacceptable—for example, pricing the contract as above by using the cash promised for 1979 and 1980 to finance it, those salary rises then being forgone), the sooner that it is flushed out into the open the better. The profession will then be left with the choice of abandoning either the new contract or the Review Body. The latter will be the sensible move and one which the juniors have had forced on them by the Review Body's inability to cope with their new contract.

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- ¹ Review Body on Doctors' and Dentists' Remuneration, *Eighth Report*, 1978, p 18. London, HMSO, 1978.
² Review Body on Doctors' and Dentists' Remuneration, *Eighth Report*, 1978, appendix D. London, HMSO, 1978.

Use and abuse of medical women

SIR,—Scrutator (7 October, p 1031) has reported our recent meeting in Birmingham on "the use and abuse of medical women." This meeting was originally planned by Birmingham and District Medical Women's Association to bring to the notice of our colleagues, male and female, the continuing need for the existence of the Medical Women's Federation. The lively debate following the talks by Dr Anne Gruneberg and Dame Josephine Barnes certainly underlined the problems still faced by medical women in 1978.

I hope that Dr Mary White will not be upset if I include her, with myself, as an older medical woman. There are several differences in circumstances nowadays from when her children and mine were small. The difficulty in getting domestic help and its cost compared with our salaries has increased many fold. Postgraduate training is now necessary (if not yet mandatory) in all branches of medicine. Three main conclusions must be drawn: (1) Medical women will suffer financially if there are not some changes—for example, cost of domestic help given income tax relief. (2) Women medical graduates must realise what is ahead of them and plan accordingly—for example, possibly complete their training before starting a family. (3) Medical colleagues who consider and give advice on postgraduate

training and availability of part-time jobs should bear in mind the problems of medical women. One of our members has commented to me, "It is surely desirable that all intelligent women should have the same right to procreate as other women and that their children should also have the same right to parental care as other children."

We recognise the possibility of future over-manning (or should I say over-personing?) in the medical profession. The profession must stand together on this problem of medical manpower to prevent a situation arising in which there will be unemployment; in these circumstances women would be likely to be the first to be affected.

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Medical Women's Association

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Payment of ancillary staff

SIR,—I note the considerable discussion now prevalent regarding payment to general practitioners' ancillary staff. What I have not seen mentioned, and is of the greatest importance, is the situation caused by "natural wastage."

Like many practices, ours has been trapped in the successive pay restrictions so that we have only been able to raise salaries on the annual percentage basis. In our opinion our staff were originally remunerated adequately on the then existing market rates. But of course the private sector has been quietly uprating secretarial salaries far beyond Government guidelines, either quite openly or masked under various "deals."

We are now faced with two unpalatable facts. Existing staff who have been with us for years and are worth their weight in gold are being paid way above salaries that the family practitioner committee will reimburse. Secondly, and much worse, new staff must be paid at the same *old* rates as the original staff. We are now paying our secretaries and receptionists over £1000 per annum above original rates which are not reimbursable. Thus we are losing more than £700 per annum from legitimate income. We even tried to turn our senior secretary into a practice manager, but that approach got a very dusty answer. So a good part of our "rise" is going straight out to staff and other practice expenses, resulting in a financial standstill for the doctors.

Finally, we note that many applicants for secretarial posts at £1.50 to £2 per hour are utterly incompetent. Their grammar is appalling, they can't spell, and half seem to suffer from dyslexia. Perhaps the Government does know best even if its interpretation of reimbursable salaries for ancillary staff is outrageously immoral.

H P WATSON

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Prescribing and family planning

SIR,—Prescribing is an integral part of medical practice and only a doctor may prescribe. Prescribing can never be delegated to anyone, even another doctor, for each doctor must be responsible for his own. No nurse does, can, or ever shall prescribe. This last because no defence society will ever indemnify any doctor against deliberately covering a person unqualified in this respect, such as a nurse.