Effect of two-week course of pivmecillinam or mecillinam in a group of 18 convalescent faecal excretors of non-typhoid salmonellas

Drug	Daily dosage	No of courses	No of patients becoming non-excretors
Pivmecillinam	400 mg × 3	6	0
Mecillinam	185 mg × 3	4	1
Mecillinam	370 mg × 3	6	2
Mecillinam	370 mg × 4	6	2
Total		22	5

before treatment ranged between 5 and 18 weeks (mean 10 weeks). Of the 18, 16 had an uncomplicated history while two had a history of biliary disease. The drugs were well tolerated and only one patient, who was given pivmecillinam, had to stop treatment because of side effects (anorexia and nausea). The serotypes of the patients' organisms were: *Salmonella anatum*, 3; *Salm hadar*, 3; *Salm typhimurium*, 2; *Salm panama*, 2; *Salm kedougou*, 2; *Salm paratyphi B*, 1; other serotypes, 5. All isolates were initially sensitive to mecillinam (10 µg) by disc diffusion and in only one case did resistance emerge after two weeks' treatment.

Conversion to the non-carriage state was accepted after six consecutive negative stool cultures over three or more weeks. Of the 18 patients, only five ceased to excrete after treatment (see table). By comparison among 18 untreated excretors of similar age an average of 25% of those remaining positive lost their infection every 14 days. It is possible that the antimicrobials might prove more effective if used in higher doses or in more prolonged courses of treatment.

Patients treated successfully by Jonsson and Tunevall¹ had been excreting organisms for more than one year and nearly all had biliary disease. It therefore seems likely that pivmecillinam cured these chronic carriers by eradicating biliary infection. The exact site of infection in convalescent carriers is unknown, but in our experience few such patients have a history of biliary disease. Mecillinam, which is poorly absorbed from the gut lumen, would seem a rational choice for these patients, but whichever drug is chosen the chances of successful treatment are low since previous studies have shown that antimicrobial therapy tends to prolong rather than shorten salmonella excretion.³

We are grateful to Dr H E Parry for permission to report results from patients under his care and to Leo Laboratories Ltd for supplying the drugs studied.

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¹ Jonsson, M, and Tunevall, G, *Infection*, 1975, 3, 31.
² Jonsson, M, *Journal of Antimicrobial Chemotherapy*, 1977, 3, suppl B, p 103.

³ Dixon, J M S, *British Medical Journal*, 1965, 2, 1343.

Facilities for junior doctors in new hospitals

SIR,—Dr A M Cantor's observations (28 October, p 1224) came as no surprise to the junior doctors in this area. In five months' time, with the closure of the Royal Portsmouth Hospital, we are moving into the new Queen Alexandra Hospital, Cosham. The problems

encountered so far include: (1) a mess room for 60+ junior doctors which measures 14 ft × 24 ft sited opposite the patients' library; (2) totally inadequate telephone facilities in resident doctors' accommodation; (3) no separate dining-room facilities for medical staff; (4) junior doctors' accommodation haphazardly dispersed in residential blocks which are also used by nursing and other staff. We have, however, been promised night catering facilities but only because the TUC-affiliated unions have insisted on it for their members.

We have resolved not to accept the continued decline of our working conditions in this way.

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General ophthalmic services—a practical alternative

SIR,—We read with interest the naive letter from Dr M J Ball (28 October, p 1232). It is clear that Dr Ball has no idea of the necessary requirements for refraction and proper prescription of spectacles.

Mass-produced spectacles correct for spherical aberrations only and pay no attention to astigmatic errors. At best only one eye can be corrected in the vast majority of cases so supplied. One of the fundamental reasons for attending a professionally trained ophthalmologist or optician is to exclude the possibility of asymptomatic disease. Dr Ball's proposals would turn back the clock in Britain 50 years and would be responsible for loss of sight in quite a proportion of the elderly population from such disorders as glaucoma. As full-time ophthalmologists we have no financial interest in firmly rejecting Dr Ball's suggestions.

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Fee for service or capitation fee?

SIR,—I have read with interest the report by Dr K C Harvey regarding the Ontario Health Insurance Plan (28 October, p 1241).

I have spent a period of time in Canada and worked with the Alberta Health Care Insurance Commission Plan; I have also worked as a general practitioner in Britain. There is no doubt that the fee-for-service system of payment raises the standard of medical care to the patient and is fairer for the doctors concerned, in that it is the doctors who undertake the work who are suitably rewarded, unlike the NHS in this country, where the capitation-fee system does not ensure fair rewards for work undertaken. I find it interesting that although many objections have been raised to the introduction of a fee-for-service system of payment in Britain, most general practitioners accept this system as a matter of course for maternity payments, contraceptive services, and immunisation procedures.

The objections raised by Dr Harvey regarding confidentiality can be overcome, and the sooner the NHS changes the system of payment to fee-for-service the sooner the standard of care of patients in this country will improve.

T D WHITEFIELD

Leeds

Weekend dental treatment

SIR,—In the Folkestone and Hythe district the local dentists run a weekend emergency rota. It is not within the NHS and the minimum treatment is £4. The service is advertised in the local paper. The police, local authority, hospitals, doctors, chemists, and telephone service also have the relevant address for any particular weekend.

During the 19 weeks from Saturday 8 July the service treated the following number of patients: Saturdays—total 44, average 2.32; Sundays—total 29, average 1.53; bank holidays—1, average 1. The service has been in operation since January this year.

I think the figures bear out the Department of Health's contention that there is no real need for a weekend emergency dental service. I know many doctors complain about the lack of weekend dental treatment but understand that many calls for dental pain are from patients who have no intention of seeking any dental treatment whatsoever.

M BIERMAN

Folkestone, Kent

The Safety Net and preregistration posts

SIR,—While reading the recent article by Dr G A Moge (21 October, p 1136) I couldn't help but wonder whether the author had any knowledge of the situation which exists in Leeds with regard to house jobs.

He states that "some schools already make their allocation of posts well before the final examinations, and some consultants... offer appointments as much as a year ahead." In the Yorkshire Region at the moment there is a slight surplus of posts and for this reason, or else for reasons best known to themselves, consultants allocate posts, very often to the first person who gets along and asks for the job, up to two years and more in advance of final exams. This means that students having completed just one year of clinical studies are being pressured into applying for house jobs because they know that if they don't then the best will soon have gone. It may seem unbelievable but it is true that the majority of medical house jobs in Leeds itself for the period August 1980 to August 1981 have already been allocated.

Although I can sympathise with my colleagues in the metropolis regarding the uncertainty that exists concerning their future employment, I feel the opposite situation is just as bad since it is unfair to ask any medical student to consider which job he or she would like in two years' time. How long will it be before it is necessary to state house-job preferences on one's UCCA form when applying for Leeds Medical School?

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Leeds