CORRESPONDENCE

Correspondents are asked to be brief

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Isolation System for General Hospitals

SIR,—Infections of low communicability can be contained relatively easily by techniques designed to limit contact transfer. In planning for the future, however, it is important not to make facile and inappropriate application of historic experience. In earlier years poliomyelitis appeared to be poorly communicable—case - to - case transmission and more than one case per family were considered exceptional when most of the population was immune as a result of clinically trivial infection in early childhood. In present conditions, unless susceptible populations have been protected by vaccination, transmission routes may be more obvious and I have personally seen one family in which four members were afflicted by paralytic poliomyelitis (fatal in one child) during a village outbreak in the Netherlands.¹ The

analogy with hepatitis is clear. If social and hygienic conditions continue to improve we may not in future be able to get away with arrangements which appeared adequate in the past, particularly in the vulnerable populations concentrated in hospitals.

Dr. H. G. Easton (11 May, p. 331) may rest assured that the selective, economical, and efficient use of special facilities and limited resources in this field is the current concern of expert individuals, committees, and national and international conferences.²—I am, etc.,

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¹ Bijkerk, H., et al., *Nederlandsch tijdschrift voor geneeskunde*, 1972, 116, 549.
² Grist, N. R., *Lancet*, 1973, 2, 1340.

Tetracycline Poisoning in Renal Failure

SIR,—Dr. M. E. Phillips and his colleagues (20 April, p. 149) point out that some of the tetracyclines produce a fall in the glomerular filtration rate and can be poisonous to patients with renal impairment. Then the doctor who gives the drug may become the object of medicolegal proceedings. This unhappy situation can be avoided, they say, by prescribing doxycycline, which does not cause a rise in blood urea.

I accept entirely that this is a wise and timely paper. But there are three ways in which a diligent and conscientious general practitioner might fall into error:

(1) Renal impairment is likely to be symptomless and the patient often does not

understand the nature of his illness. The diagnosis can be missed, particularly if the clinical situation is dominated by an infection elsewhere.

(2) Proteinuria is not unknown in febrile illness. Such an illness is often revealed to the practitioner during anti-social hours when the chances of getting biochemical investigations done are not great.

(3) The general practitioner is urged by the Department of Health to avoid using expensive preparations. The present price of doxycycline (Vibramycin) is £26 per 100 tablets and that of oxytetracycline £1.17. It is thus unlikely that he will carry doxycycline in his emergency bag and make it

first choice for patients with respiratory infections in whom only the possibility of renal impairment exists.—I am, etc.,

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Beta-blockade in the Presence of Renal Disease and Hypertension

SIR,—It was with some surprise that we read the conclusion reached by Dr. D. J. Warren and his colleagues (27 April, p. 193) on the basis of observations on three patients with hypertension and renal failure that beta-blocking drugs "should not be given to patients with moderately severe renal failure." No mention is made of the number of patients treated in whom a diminution of renal function was not seen. In the three cases quoted beta-blockade was on no occasion the only therapy. Two of the patients received propranolol and one oxprenolol. If one were to draw the obvious conclusion from the opinion stated one would have to infer that beta-blockade was in itself a dangerous form of therapy.

During the past three years we have treated 69 patients for a minimum of six months with propranolol alone. Despite adequate control of the blood pressure, in no case has there been a fall in renal function such as to cause a change in the patient's clinical condition. In the accompanying table the mean findings before treatment with propranolol (initial) and at the last follow-up (final) are given for the group as a whole and also subdivided according to their initial creatinine clearance (I.C.C.).

From these results it is apparent that no