Antibiotics in surgical treatment of acute abscesses

SIR,—I am pleased to see that primary closure, under antibiotic cover, of acute superficial abscesses continues to be advocated (12 July, p 111). However, it is surprising that the investigators of the trial prescribed a five-day course of clindamycin for one-quarter of their patients, since the Committee on Safety of Medicines, in June 1979, recommended that this drug "should in general be reserved for *serious or life-threatening* conditions where other antibiotic therapy is ineffective or undesirable."¹ This recommendation was made because of the well-known association between clindamycin and antibiotic-associated colitis.

Dr P W H Blick and others have, however, shown that a *single* preoperative dose of clindamycin provides adequate antibiotic cover when closing an abscess cavity by primary suture. This is an important finding as a single-dose method might reduce the (admittedly small) risk of inducing pseudomembranous colitis to infinitesimal proportions and allow the method of primary closure, with this antibiotic, to be advocated widely once again.

While I too have found that the time needed for skin healing after incision, curettage, and primary suture under antibiotic cover is rather less than that after incision and open drainage, I believe that the main advantage of the former technique is that it allows the patient to return to work sooner; there is no need for him to remain at home for nursing visits or to make daily trips to hospital for dressings.²

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¹ Committee on Safety of Medicines. *Adverse reaction series*, No 17. London:HMSO, 1979.

² Murie JA. *J R Coll Surg Edinb* (in press).

*We sent this letter to the authors, and Mr Wilson's reply is printed below.—ED, BMJ.

SIR,—I do not think that Mr Murie would want his comments about our choice of antibiotic to detract from the main purpose of the paper. This was to report our findings that a single preoperative dose of an effective antibiotic is sufficient chemotherapy to permit primary closure of an acute abscess after thorough curettage, and that a course of postoperative antibiotic therapy does not further enhance the healing process.

However, referring to the Committee on Safety of Medicine's circular of June 1979, Mr Murie expresses surprise that clindamycin was the antibiotic which we used to establish this surgical principle. On reflection I am sure he will appreciate that the protocol for the trial had been prepared much earlier than June 1979. In fact, the trial was almost complete by the time the letter was issued. Nevertheless, I must report that, despite the Committee's letter, we still use clindamycin for the treatment of acute soft tissue infections because of the excellent clinical results it provides for our patients. This decision is based on a five-year study of 15 019 patients treated in our own department, which revealed that only 1 in 1000 patients developed diarrhoea of five or more motions in 24 hours, and in only two of

these patients were there symptoms of pseudomembranous colitis.¹

Most of the fatalities from pseudomembranous colitis associated with clindamycin therapy have been in elderly, debilitated patients with severe chronic illness. Many of them were already suffering from diarrhoea before clindamycin or lincomycin was added to their therapy in a forlorn hope of reversing terminal symptoms. These unfortunate patients are in stark contrast to the ambulant, young patients (mean age 26 years) who attend our department suffering from an acute soft tissue infection.

In view of the recent advances in our understanding of the nature of antibiotic-associated colitis, especially the role of *Clostridium difficile*, and the discovery of vancomycin and possibly metranidazole as specific therapeutic agents, we feel justified in continuing to use this valuable antibiotic for the treatment of acute soft tissue infections, but with certain reservations. It should not be used for patients who have chronic colitis and it is possibly unwise to use it for elderly, frail patients. Provided that any young, otherwise healthy patient who develops severe diarrhoea seeks immediate treatment, we consider the risk to be minimal.

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¹ Wilson DH. *Br J Surg* 1980;67:93-6.

Jejunioleal tuberculosis

SIR,—I was pleased to see our article in the *BMJ* (12 July, p 118). It has been brought to my attention, however, that we have not properly acknowledged the help which we received from our pathologist colleague in the preparation of the figure, and I would just like to take this opportunity to thank him for his expert assistance (Dr C Burrows, consultant pathologist, Walton Hospital, Rice Lane, Liverpool 9).

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Genital herpes

SIR,—Your recent excellent leading article (7 June, p 1335) on genital herpes contained two statements worthy of comment: "Genital herpes is commoner than primary syphilis, from which it must be differentiated" and "Syphilis must be excluded." The implication is one of mutual exclusiveness. In fact, sexually transmitted diseases frequently coexist, and even when virologically proved genital herpes has been diagnosed all genital ulcers must be submitted to dark-ground microscopy. The fluorescent treponemal antibody absorption test can be misleading. False-positive results occur in genital herpes,¹ and if dark ground microscopy is not used cases of syphilis may be misdiagnosed.

Occam's razor does not apply in venereology. The presence of one sexually transmitted infection implies either promiscuity or intercourse with a promiscuous partner, and promiscuity implies the risk of acquiring multiple infections. Multiple causes of venereal infection must be actively sought as many of these infections may be asymptomatic. In one series² of virologically proved genital herpes

seven also had gonorrhoea, two had trichomoniasis, three had candidiasis, and one had warts. In another series¹ of 32 virologically proved cases of genital herpes one had gonorrhoea, one had non-specific genital infection, two had trichomoniasis, and two had candidiasis.

It therefore follows that the management of genital herpes should include an active search for any associated, possibly asymptomatic, and potentially damaging sexually transmitted disease.

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¹ Wright JT, Cremer AW, Ridgway GL. *Br J Vener Dis* 1975;51:329-30.

² Beilby JOW, Cameron CH, Catterall RD. *Lancet* 1968;i:1065-6.

Children in wheelchairs

SIR,—In Contemporary Themes the important topic of children in wheelchairs was discussed by Alison Wisbeach and Professor K S Holt (19 July, p 199). Much of what was stated applies equally to the adult wheelchair users in corresponding categories. May I draw the attention of your readers to that excellent book by Dr Phillipa Russell,¹ which I have recently read, because it gives a first-hand, comprehensive account of the care of children in wheelchairs and enables one to appreciate the problems by putting them in perspective. Although I am myself an adult in a wheelchair, I learned much from the author, who I understand is the mother of a wheelchair child. From a technical standpoint much more can be gained from the proceedings of the seminar on rehabilitation of the disabled held at the University of Strathclyde, Glasgow, in 1978, one of the Strathclyde bioengineering seminars. It appears that there is indeed more co-ordination between the workers caring for the disabled in Scotland than is apparent in England and, in addition, more educational facilities for those who elect to do this work—for instance, a National Centre for Training in Prosthetics and Orthotics. With the Year of the Disabled in mind (1981) may I suggest that such an educational project be made available in this country.

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¹ Russell, P. *The wheelchair child*. 2nd ed. London: Souvenir Press, 1978.

Seating the disabled

SIR,—We were delighted to read the leading article on seating the disabled (5 April, p 963), which raises the following points.

(1) The complex factors that maintain stability and protect from injury—that is, promote tissue viability—have received a good deal of attention. It may seem otherwise because the published work is scattered in time and space, across many disciplines (not necessarily medical), in various specialist journals. General journals such as yours can correct this.

(2) You say in your editorial, "As is so frequently the case, no single organisation has clear responsibility for initiating and seeing through the creation of a seat support for the disabled." Seating includes cushions and chairs and is one part of "support systems." Support systems form one aspect among many of the

management of tissue viability disorders such as pressure sores. It would be unwise in principle for one group to concentrate research on a universal seating system because, firstly, the system of care of which it is an important part is inefficient and poorly organised; secondly, there is unlikely to be a crock of gold at the end of the technological rainbow—that is, patients and diseases are so diverse that a variety of cushions and seats is desirable; and, thirdly, proving the device would be a multicentre exercise. For beds and mattresses the case for variety has been argued in detail, and the conclusion reached that present technology is adequate if available and properly used. In other words, the system of care requires more attention.^{1 2}

(3) We entirely agree that skills such as those of the biomedical engineer are available to solve the problems that can be formulated.³ We believe that the DHSS demonstration centres and Scottish aids centres already play major parts and may have solved the problems of the team approach. The concept of multicentre, multidisciplinary special interest groups has been described^{4 5} and a national group to deal with tissue viability disorders meets three times a year. This tissue viability group has a cushion and seating section,⁶ which meets for the third time on 17 September, when six papers will be read.

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¹ Kenedi RM. *Bed sore biomechanics*. London: Macmillan, 1976.

² Robertson J C. *Nursing Mirror*, supplement; May 1979.

³ Ferguson-Pell M W, Wilkie I C, Reswick J B, Barbenel J C. *Paraplegia* 1980;18:42-51.

⁴ Wessex Rehabilitation Association. *Annual Report*. Salisbury, Wessex Rehabilitation Association, 1979.

⁵ Robertson J C. *Salisbury Medical Bulletin* 1979; 368-70.

⁶ Spinal Injuries Association. *Newsletter* 1980;15:4.

Respiratory infections in the older infant

SIR,—In his article on respiratory infections in the older infant (14 June, p 1442) Dr H B Valman discussed the examination of a child's throat, always an unpopular task for any physician. An adult armed with a light and a piece of wood (spatula) approaching a child from the front must often appear threatening, particularly when the child is feeling unwell. Having experienced the resultant lack of co-operation, and because I had done anaesthetics just before starting general practice, I adopted a different method. It has stood me in good stead over the last 15 years, and may be of some interest to others who have struggled for a view of a young child's throat.

With the child sitting on the parent's lap and facing away from you, ask if they can be laid down backwards. Draw your chair up so that the child's head is resting on your knees.

By this time they are generally reduced to an astonished silence. As you look over the child's forehead, with the aid of the spatula the mouth opens readily to give an excellent view. Children over the age of about 3 have generally done it all before, and open their mouths like hungry thrush fledglings.

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Brachial plexus injuries in motorcyclists

SIR,—I was interested to read Mr C B Wynn Parry's letter (12 July, p 149) and would support his view that amputation of the paralysed arm is no longer the treatment of choice in patients with preganglionic lesions. They seldom wear an artificial limb for functional or cosmetic reasons and the psychological effect of amputation should not be underestimated. The flail arm splint described by Dr Wynn Parry¹ may be helpful and some patients seem to manage well without any appliance.

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¹ Wynn Parry CB. *Injury* 1979;11:265-85.

Care of the unconscious

SIR,—Dr Jean M Horton describes a simple systematic approach to the management of the long-term unconscious patient (5 July, p 38). While such an approach is essential if some important aspect of care is not to be missed, inevitably the patient becomes dehumanised. Therefore, I believe that three further aspects of care should be added to Dr Horton's list.

Firstly, there is a need for care of the psyche as the conscious level rises. Sensory deprivation, pain, fear, etc, can all prolong recovery to full consciousness. Secondly, there is a need for spiritual care. The priest or equivalent should be a common and accepted visitor to the patient, and not seen as merely a harbinger of doom or administrator of last rites. Thirdly, the patient's relatives need care and attention.

These aspects are as important as physiological and pharmacological management in the total care of the unconscious patient.

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Trial of synthetic steroid for preventing postmenopausal osteoporosis

SIR,—The reported trial of the synthetic steroid Org OD14 in the prevention of postmenopausal osteoporosis by Dr Robert Lindsay and others (17 May, p 1207) does not mention changes in the height and weight of the trial patients. As the authors show that

Org OD 14 is significantly better than placebo in preventing osteoporosis perhaps one may presume that the patients taking steroids maintained their initial height. During the course of therapy with an anabolic steroid did they also gain weight?

Cochrane *et al*¹ have demonstrated a strong positive association between the Quetelet Index (weight/height²) and total mortality in women aged 55-64 years. Increase in weight at the menopause is not desirable on medical or aesthetic grounds. If long-term treatment with an anabolic steroid such as Org OD 14 is accompanied by a significant increase in weight many women would feel that this was too high a price to pay for the prevention of bone loss.

The authors describe the initial mean values of height and weight for the trial patients: could they possibly provide similar data for the groups after two years' treatment?

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¹ Cochrane AL, Moore F, Baker IA, Haley TJL. *Br Med J* 1980;280:1131-3.

*We sent this letter to the authors, whose reply is printed below.—Ed, *BMJ*.

SIR,—We thank Dr Coope for her interest in our publication (17 May, p 1207) and for her comments. The point she makes is an important one. Final height and weight measurements were omitted from our publication simply because no significant changes occurred during the two years of the study (see accompanying table).

In our larger, long-term study of oophorectomised women we have shown previously that hysterectomy with bilateral oophorectomy is associated with subsequent weight gain, which does not occur after hysterectomy alone.¹ Almost all weight gain occurred in patients who were already overweight at the time of the operation and was not apparent in women of normal weight. The provision of postmenopausal oestrogen therapy prevented weight gain in these obese women.

In our current study, as Dr Coope correctly points out, we have used a steroid with an unusual endocrine profile. Only nine patients treated with Org OD 14 for two years were overweight (>20% in relation to height) at the start of the study and two gained weight during the study. In the placebo group ten were overweight at the start and four of those patients gained weight. Mean weights and heights for the two groups did not change during the study.

Despite the general hypothesis that there is a direct positive relationship between weight and mortality, this is in fact not totally suggested by the Framingham study.² This study shows minimum mortality around the average weight, with increasing mortality with both increasing or decreasing weight. In fact age-adjusted six-year mortalities among women in the Framingham study are almost as high (3.7%) in the leanest group as they are in the

Heights and weights (means $\pm$ SD) of women in trial

Group	Height (cm)		Weight (kg)	
	Initial	Final	Initial	Final
Org OD 14	159.0 $\pm$ 1.2	158.9 $\pm$ 1.1	60.4 $\pm$ 1.4	61.1 $\pm$ 1.7
Placebo	160.5 $\pm$ 1.1	160.2 $\pm$ 1.0	63.3 $\pm$ 1.4	62.4 $\pm$ 1.8