expect Sir John Peel to honour the 1962 report?—I am, etc.,

Rainham,
Kent.

J. RUFFELL.

REFERENCE

- ¹ *Recommendations on the Principles and Organization of General-Practitioner Maternity Units and Their Relation to Specialist Maternity Units*, 1962. Royal College of Obstetricians and Gynaecologists, London.

SIR,—The letter from Sir John Peel (14 September, p. 678) states: "The evidence is plain for those who care to read without prejudice that the small isolated general-practitioner maternity unit is at best one of the least safe places in which a patient could be delivered." Who is prejudiced? Surely "the evidence" referred to all deliveries under general practitioners, including many which had virtually no antenatal care (not even one estimation of Hb). No work whatsoever has been done to compare hospital confinements with those in general practice which have been adequately supervised, yet we frequently hear sweeping statements like Sir John's from obstetricians based on very incomplete evidence. Results must depend more on the training and conscientiousness of doctors in charge of maternity cases and not on where the delivery takes place.

The time when all deliveries will be done in large institutions is in the distant future. In the meantime everything should be done to improve the facilities in maternity units and the standards of general-practitioner maternity care in them, as they will have to continue functioning for a long time to come, and possibly in rural areas indefinitely. The attitude of consultants, as expressed in Sir John's letter, can only make the work done in general-practitioner maternity homes more difficult and worrying for the conscientious doctor.—I am, etc.,

Clitheroe, Lancs.

R. HARRISON.

SIR,—In his appraisal of your leading article on general-practitioner obstetric units (7 September, p. 567) our former chief and teacher, Sir John Peel (14 September, p. 678), appears to reject the cake because he dislikes the cherry on the top. While completely unable to provide "proper" institutional facilities for the country at large—and this is likely to remain so for our lifetime and beyond—he himself appears to wish to set the clock back by denying to the general-practitioner obstetrician those facilities for safer childbirth which are detailed in your leading article and which are provided most effectively at a general-practitioner unit. Nor does he pay any attention to the second half of your article, which stresses the need for postgraduate vocational obstetric training such as has been pioneered by the school at St. John's Hospital, Chelmsford, under Mr. David Brown.

By all means let us have the closest possible integration with our specialist units, but there must be many areas like ours where the nearest unit is twenty miles and more away. Unless and until Sir John's cloud-cuckoo-land ideal materializes, there will be domiciliary midwifery, and general-practitioner units are a logical extension of this. By robbing us of our general-practitioner units Sir John will either cause the specialist units to

be flooded with normal cases or else he will compel us—general-practitioner obstetricians and district midwives alike—to revert to the conditions where one's prayerful attitude (on one's knees by a caravan bedside) is itself a pungent comment on the sort of obstetric practice from which we have been struggling to emerge.—We are, etc.,

J. A. RICHARDS.

J. NICKSON.

P. D. ARNOLD.

Newbury, Berks.

SIR,—With great respect I suggest that both Sir John Peel (14 September, p. 678) and your leading article (7 September, p. 567) are arguing from false premises. It is not institutions but midwives and obstetricians who make childbirth safe for the women of Britain. The enormous improvement in the safety of childbirth during the last 25 years has been due to experts working in hospitals, but these institutions have been mostly converted workhouses, hardly ideal maternity hospitals. The fallacy lies in believing that more up-to-date hospitals will automatically produce better midwifery.

I know there is a teaching that we should move toward 100% hospital confinements. But there is no doubt in my mind that this will deprive a woman of her right to the joy of a normal confinement in her own home. There are at present two main difficulties to this right. First, the inadequacy of houses. For this the small maternity home will provide an incomplete, but we may hope temporary, answer. Second, the impossibility of foretelling that any woman is bound to have a normal confinement. It is, of course, slightly easier to provide specialist cover for a woman being confined by a pupil midwife in hospital, when a complication arises suddenly, than to provide cover for a general practitioner delivering the woman in her own home. However, let no one suppose that what is not so easy is impossible. General practitioners traditionally take pride in overcoming difficulties and it is really only lazy always to take the easy way out.—I am, etc.,

Girton,
Cambridge.

CLEMENT W. WALKER.

SIR,—May I take this opportunity both to support to the full Sir John Peel's recent letter (14 September, p. 678) on the subject of general practitioner maternity units and to amplify somewhat the arguments already put forward against the proposals to establish in "every town, suburb, and large village" small maternity homes provided with a well-equipped delivery room and several bedrooms?

Although a survey of some 8,000 labours among the high-risk groups which I recently undertook on behalf of the North-west Metropolitan Regional Hospital Board admittedly provided some evidence that delivery in the home, in a maternity home, or for that matter almost anywhere else can in some circumstances be perfectly safe, it was also once again obvious that complications involving the foetus or the mother are apt at any time to arise in a sudden and totally unexpected manner. When obstetric abnormalities of this sort are encountered in hospital practice they can usually be dealt with speedily and safely, but for obvious reasons this is not the case when they occur

in situations where the special facilities they call for are not so readily available. Lacking such facilities, the maternity homes envisaged in the report of the Royal College of General Practitioners,¹ if brought into being, would inevitably be associated with an immediate rise in the perinatal and maternal mortality and morbidity rates. In addition to this, if past experience is any guide, such institutions would prove costly to provide, expensive to maintain, cumbersome to administer, and well-nigh impossible to staff to any acceptable standards of safety.

It seems a pity, when so many changes and improvements are so clearly overdue in the field of general practice, that the Royal College of General Practitioners should choose to devote its time and energies to elaborating schemes of this nature.—I am, etc.,

Whittington Hospital,
London N.19.

R. G. LAW.

REFERENCE

- ¹ *Obstetrics in General Practice*, the report of a working party, the Royal College of General Practitioners, 1968.

Capillary Blood and Arterial Po₂

SIR,—We are glad to see that Dr. J. MacIntyre, Mr. J. N. Norman, and Professor G. Smith (14 September, p. 640) have confirmed our finding¹ that ear lobe samples can be used as an alternative to arterial samples for the estimation of arterial oxygen tension (Po₂). In our study vasodilatation was produced by radiant heat, and there was close agreement between capillary and arterial samples in subjects whose Po₂ lay in the range 50–100 mm. Hg.

As subjects, we found that ear lobe sampling was less uncomfortable than arterial sampling, and we suggest that wherever possible the less uncomfortable procedure should be used on patients. The method has also been used successfully in the investigation of industrial populations,² where moderate discomfort in a few subjects may seriously impair attendance.—We are, etc.,

JEAN H. M. LANGLANDS.

Respiratory Investigation Unit,
Musgrave Park Hospital,
Belfast.

WILLIAM F. M. WALLACE.

Department of Physiology,
Queen's University,
Belfast.

REFERENCES

- ¹ Langlands, J. H. M., and Wallace, W. F. M., *Lancet*, 1965, 2, 315.
² Wallace, W. F. M., M.D. Thesis, 1966, Queen's University, Belfast.

Drugs for Tuberculosis

SIR,—May I be allowed to comment on your contributor's account of drugs for tuberculosis in your "Today's Drugs" section (14 September, p. 664)? Mentioning that drug allergies to streptomycin and para-aminosalicylic (P.A.S.) acid occur in 5%–10% of cases, the writer states that desensitization "is usually successful," but that this involves the immediate stopping of all drugs, and that during desensitization drug resistance may develop, and, moreover, that desensitization should not be attempted in patients who have developed hepatitis, exfoliative dermatitis, etc. "Very occasionally the offending drugs may be continued under corticosteroid cover when desensitization has

been unsuccessful. It is usually possible to tail off corticosteroid dosage after three months." It is not suggested by the writer that desensitization may have occurred meanwhile.

In fact desensitization to streptomycin and P.A.S. is regularly obtained when steroids in adequate dosage are added to the drug regimen, there being no need to interrupt full chemotherapy with the offending drugs, because hypersensitive reactions are suppressed. Hepatitis or exfoliative dermatitis is not a contraindication.¹ The risk of drug resistance is not incurred. The patient under this regimen is rapidly, and apparently permanently, desensitized. Some writers have found that desensitization is achieved in ten days by this technique.² Moreover, the patient so treated has the significant advantage of receiving steroids as an adjuvant to chemotherapy. It is probable that just as Type IV allergy to drugs is overcome under steroid cover so is Type IV allergy to the tuberculous antigen. It has been shown repeatedly in Britain and elsewhere in many controlled trials that there are statistically significant advantages in using steroids in cases of active and extensive pulmonary tuberculosis, in that clinical recovery and radiological clearing are much more rapid and the degree of residual fibrosis is less. Your contributor speaks of the necessity for continuing chemotherapy for two or three years in cases of advanced pulmonary tuberculosis. This is presumably because viable tubercle bacilli may have become sequestered in fibrous tissue, a situation which would be avoided if corticosteroids were introduced at an early stage of treatment. Although the elimination of tubercle bacilli is a prime motive for treatment with antituberculous drugs, there are other factors which are worthy of consideration, such as the patient's reactions to the tubercle antigen, the duration of his illness under treatment, and the extent of lung damage which is incurred when inflammatory processes are allowed to continue unnecessarily.

Your contributor also dismisses the use of steroids in all forms of tuberculosis, including meningitis, but it is not difficult to recall cases such as the following. A child suffering from miliary tuberculosis and meningitis developed severe drug reactions to streptomycin and P.A.S., which at the time were the only drugs available, and the prognosis was therefore virtually hopeless. Under steroid cover the drugs were continued and recovery was swift and uneventful.

Support for the view that doctors in this country are perhaps misinformed about the value of corticosteroids in pulmonary tuberculosis is given in an annotation in another journal.³ Giving a comprehensive review of world publications on this subject ("a Cinderella-story"), the writer concludes as follows: "Those who . . . spoke for it [hormone therapy] in the difficult early stages can be satisfied that they have contributed to the most significant development in the treatment of tuberculosis since the introduction of chemotherapy itself." It is a pity that your contributor, in his otherwise authoritative review of drugs for tuberculosis, should have dismissed corticosteroids in six lines.—I am, etc.,

London W.1.

L. E. HOUGHTON.

REFERENCES

- Houghton, L. E., *Lancet*, 1954, 1, 595.
- Francis, R. S., and Gupta, S. K., *Tubercle (Lond.)*, 1958, 39, 236.
- Lancet*, 1966, 1, 192.

Bacteria in Urine

SIR,—I find it puzzling that articles on urinary tract infections (7 September, p. 600) never seem to mention that organisms can be clearly seen in the unstained urine under the 4th objective.

The interpretation of this finding is not necessarily easy, but the presence of visible organisms seems to me to be a useful observation comparable to the presence or absence of pus cells.—I am, etc.,

Oxtd,
Surrey.

J. H. LANKESTER.

Pain in the Face

SIR,—As a neurosurgeon whose life is crowded with patients suffering from pain in the face, I approached Professor Henry Miller's oration (8 June, p. 577) with more than passing interest. I have long counted myself among his admirers, and found myself increasingly dismayed as I discovered how much I disagreed with almost everything he said.

It is true that Tegretol (carbamazepine) has transformed the management of this common malady. A significant proportion of the many patients who respond to the drug cease to do so, however, after a period of time which may vary from six months to six years. These folk, added to those who are intolerant or unresponsive, constitute a hard core of cases which will always require some form of surgical treatment. Professor Miller misleads when he says "alcohol injection of the Gasserian ganglion has lost its vogue . . . the technique is difficult and the result unpredictable." The truth of the matter is that—properly done—alcohol injection of the sensory root is the only safe, certain, once and for all, permanent cure, having a small morbidity and no mortality. No other form of treatment qualifies for such a description, and the recurrence rate after limited root section is not "small" but on the contrary considerable.

The great problem indeed lies in the difficulty of injecting the sensory root properly; the technique "has lost its vogue" because few neurologists or neurosurgeons (and I am not myself one such) have trained themselves to do it. To play the violin well is difficult, too, but it has not lost its vogue.

Nerve division operations for malignant pain in the head, face, throat, and neck are among the most satisfying and gratifying in the surgery of advanced malignant disease. They are not in the least mutilating, usually confer total relief from pain, have a surprisingly small mortality, and are infinitely to be preferred to a drugged, befuddled, agonized process of dying.—I am, etc.,

JULIEN C. TAYLOR.

Derbyshire Royal Infirmary,
Derby.

SIR,—Giant-cell arteritis is often overlooked, although a common condition and one frequently causing blindness in one or both eyes in old age. Mr. Martin Joyce (24 August, p. 498) has pointed this out, in response to the view of Dr. R. W. Barter (27 July, p. 251) that arteritis is a self-limiting disease, but the need for urgent treat-

ment is not stressed. The second eye may become blind within hours of the first being affected, and while it is justifiable to await the result of an E.S.R. estimation, which takes an hour, it is certainly not right to wait for an arterial biopsy to be arranged. This procedure may be undertaken as confirmation in doubtful cases, and many are atypical with little or no pain. Prednisolone should be given at once in dosage of 60 mg. a day, and gradually reduced as symptoms and the E.S.R. respond, but should be continued for six months and often for longer.

Treatment is very effective in preventing further loss of sight, but almost useless in recovering that which has been lost, so time is of prime importance.—I am, etc.,

R. A. D. CRAWFORD.

Kent and Canterbury Hospital,
Canterbury.

Antibiotics in the Treatment of E.N.T. Infections

SIR,—In this interesting article (24 August, p. 480) your expert notes that most boils are due to *Staphylococcus pyogenes*, and that "the chances of a resistant organism are not great," so he recommends penicillin as the drug of choice. Recently I examined the figures of the numbers of throat and nasal swabs taken during 1964 from patients on admission to the infectious diseases wards of this hospital, which yielded *Staph. pyogenes*, and also the antibiotic sensitivity patterns of these organisms. Overall, out of 534 patients from whom *Staph. pyogenes* was isolated) only 169 (31.7%) yielded penicillin-sensitive strains. Among children under 5 years of age, some of whom probably carried staphylococci acquired in maternity hospitals, only 57 (20%) of 285 carriers yielded penicillin-sensitive strains. In case the situation had changed over the last few years I examined the figures for throat and nasal swabs taken in July and the first three weeks of August this year, and found that only 11 (16.9%) of the strains of *Staph. pyogenes* from 65 carriers were sensitive to penicillin. As these swabs were taken on admission of the patients to hospital, apart from a few instances where patients may have been transferred from other hospitals, they must reflect the state of carriage of penicillin-resistant strains in the local population.

It would appear, therefore, that in Glasgow at least the chances of meeting a resistant organism are, in fact, quite high, and this raises the question as to whether penicillin should ever be used to treat presumptive staphylococcal infections. In this connexion the observations of Mr. Price and his colleagues (17 August, p. 407) on the similarity of response of superficial sepsis due to penicillin-resistant *Staph. pyogenes* to treatment with phenoxymethyl-penicillin, phenethicillin, and lincomycin are relevant and intriguing, and there is certainly room for further observations on this problem. An acutely painful lesion such as a furuncle in the external auditory meatus may form a suitable subject for such a study.—I am, etc.,

R. J. FALLON.

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Ruchill Hospital,
Glasgow N.W.