menstrual period to see if the string is now visible. If the films suggest that the IUCD is no longer within the uterus the matter should be fully discussed with the patient and a laparoscopy or laparotomy performed to remove the IUCD. Fitting a further IUCD following such an abdominal procedure would seem unwise.

The apparent increase in the missing tails problem may in part be due to cutting the string too short after insertion (at least 5 cm (2 in) should be left). Investigations should not be started if there is any possibility of pregnancy (itself a cause of missing tail).

If the patient is pregnant—but that is another problem.

JOHN FRAMPTON

Warneford Hospital,
Leamington Spa, Warwicks

Disopyramide in ventricular fibrillation

SIR,—In the case referred to by Dr D P Atukorale (25 December, p 1564) the ventricular arrhythmia appears to have been "torsade de pointes."[1] This may result from overdosage with cardioselective drugs such as lignocaine, procaine, quinidine sulphate, alprenolol, or pindolol, all used by him. The arrhythmia responded to omission of these drugs. In our patient, however (2 October, 1976, p 795), the lignocaine was tailed off only when the patient responded to disopyramide; hence the cessation of ventricular fibrillation in this case could not have been due to the omission of lignocaine. Comparison of disopyramide with cardioactive agents such as lignocaine is currently under test in an open ward trial.[2]

T D I M S DE LANEROLLE

General Hospital,
Columbo, Sri Lanka

[1] Krikler, D M, and Curry, V L, *British Heart Journal*, 1976, **38**, 117.
[2] Jennings, A, *et al*, *Lancet*, 1976, **1**, 51.

Tetracycline resistance of group A streptococci from different sites

SIR,—The nationwide survey of tetracycline resistance in pneumococci and Group A streptococci (15 January, p 131) very wisely points out the necessity for making local surveys before deciding which antibiotic to use. This prompted us to review the tetracycline resistance of strains of Group A streptococci isolated in this laboratory over the past 15 months. We found that in the 305 strains isolated tetracycline resistance was almost the same in the two centres from which we receive specimens (Alton 29 out of 107 (27·1%); Basingstoke 51 out of 198 (25·8%)). The incidence of tetracycline resistance in 187 respiratory strains was 29·4% and in 118 non-respiratory strains 21·2%. This difference is not significant ($0·2>P>0·1$). This latter finding does not support the nationwide survey conclusions.

However, more interesting was the analysis of the tetracycline resistance of strains causing infection of skin and soft tissues. These were divided into three groups: "impetigo/infected eczema" (all from general practice); "superficial lesions" (consisting predominantly of infections of the hands and feet, often clinically referred to as paronychia, from general practitioners and the accident and emergency department); and "deep lesions" (consisting of abscesses from general practice and the accident and emergency department and three inpatient wound infections). The results are shown in the table.

Group	Total No of isolates	No (%) resistant to tetracycline
Impetigo/eczema ..	41	4 (9·8)
Superficial	38	8 (21·1)
Deep	19	8 (4·21)

These figures suggest that, while the locality of the patient may be important in deciding initial treatment, the locality of the lesion may be equally important.

P A BOSWELL
G E HILLIER

Department of Microbiology,
Basingstoke District Hospital,
Basingstoke, Hants

Possible immunological effect of oxprenolol

SIR,—The report of Dr L F W McMahon on a possible immunological effect of oxprenolol (4 December, p 1388) is rather in contrast with previous observations on this subject reported in the literature. Other beta-blockers in fact, like butoxamine and propranolol, are known to enhance in-vivo antibody synthesis to heterologous protein in rats,[1] although propranolol added in culture does not modify PHA-induced transformation of human lymphocytes.[2] On the contrary, a beta-agonist like isoprenaline inhibits lymphocyte transformation[2-4] and IgE synthesis in vitro.[5]

Since alpha-adrenergic stimulation by noradrenaline at physiological concentrations enhances lymphocyte transformation[2] while alpha-blockade by phenoxybenzamine depresses antibody synthesis in animals,[6-9] it might be postulated that immunodepression is related to a beta-adrenergic effect and that it can be modified according to the usual pattern of adrenergic stimulation and blockade. It could be very interesting, then, if further studies would confirm this hypothesis or, so far as Dr McMahon's letter is concerned, would provide conclusive evidence against it.

RENATO NESSI

Corporate Medical Department,
Gruppo Lepetit SPA,
Milan, Italy

[1] Benner, M H, *et al*, *Journal of Allurgy*, 1968, **41**, 110.
[2] Hadden, W J, Hadden, E M, and Middleton, E, *Cellular Immunology*, 1970, **1**, 583.
[3] Smith, J W, *et al*, *Federation Proceedings*, 1969, **28**, 566.
[4] Szentivanyi, A, *Journal of Allergy*, 1968, **42**, 203.
[5] Patterson, R, *et al*, *Journal of Immunology*, 1976, **117**, 97.
[6] Rosenblatt, E, and Johnson, A G, *Proceedings of the Society of Experimental Biology and Medicine*, 1963, **113**, 156.
[7] Pieroni, R E, and Levine, L, *Nature*, 1967, **213**, 1015.
[8] Pieroni, R E, *New England Journal of Medicine*, 1971, **284**, 793.
[9] Flier, J S, *New England Journal of Medicine*, 1971, **284**, 1159.

Antibiotic myths

SIR,—I have recently discovered that two old beliefs about the use of antibiotics are still so widely held and so misleading that they deserve publicity.

The first is that if you have started to give a patient an antibiotic and shortly discover that antibiotic to be inappropriate you must nevertheless complete the course. Five days is the usual time mentioned. Prevention of the emergence of resistance in some unspecified bacterial population is the usual reason cited.

The second misconception is that if you have decided on clinical grounds that a patient needs antibiotic treatment and have also decided to send appropriate material to the laboratory for culture you should wait for the results of the laboratory investigation before starting treatment. If a patient needs treatment with an antibiotic, he needs treatment *now*—at the time the indication for treatment is recognised. Of course, if material for culture is to be taken it should be collected before the antibiotic is given, but only just before. The antibiotic most likely to be effective should then be given. If later that agent proves inappropriate it should be stopped immediately and a more appropriate one substituted.

MALCOLM LEWIS

Public Health Laboratory,
City and Sherwood Hospitals,
Nottingham

Access to oral contraceptives

SIR,—The signatories to the letter under this heading (22 January, p 228) omit any reference to consideration of British women's own individual needs and wishes in respect of their health, wellbeing, and future fertility in using oral contraceptives. We are doctors, not vets. Many women know what the "pill" is doing—and say so.

Whatever happens in the Third World does not, surely, invalidate our medical responsibility here. When we as doctors know that the oral contraceptives' long-term effects on individual women's physiology are unknown and women themselves (for example, Sonia Behr in the *Sunday Times* of 23 January) are questioning the suppression of facts—such as the increasing frequency of post-pill amenorrhoea—are we prepared to lie to our patients about the need for continuing medical responsibility and prescription?

Is this the "exemplar to the developed world" that Judith Bury, Malcolm Potts, John Lorraine, and others want?

BETTY ELLIOTT

West Walton, Norfolk

Local gold toxicity

SIR,—Dr D C Dick (1 January, p 51) has suggested that the patient I described (27 November, p 1294) had a recurrence of a nickel dermatitis and in support of his contention he cites the observations of Stoddart.[1]

The needles used in our clinic contain 8-12% nickel and my patient was exposed to such needles on two occasions before sodium aurothiomalate was given and on several occasions since, for the purpose of venepuncture, without any untoward effect. The duration of exposure for both venepuncture and intramuscular injection is similar and short. The two cases of recurrent nickel dermatitis described by Stoddart[1] occurred in patients in whom nickel-steel-shafted infusion sets were inserted into a forearm vein during elective surgery. The duration of exposure was hours rather than seconds and the reaction manifestations were generalised in both and localised in one. In his conclusions the author