A new Seminar is now starting at Bridgnorth in Shropshire and applications should be sent to Dr Jean Grey at 9 Hall Meadow, Hagley, Worcestershire.

CORRECTIONS

Dr J. Spears

The acknowledgement section of Dr J. Spears's paper in the April *Journal* should have read as follows: I wish to express sincere thanks to Dr J. B. Peacock, Senior Research Associate, Department of Engineering Production, University of Birmingham for his statistical analyses, to Dr A. C. Kendall for his encouragement and helpful criticism, and to my partners Drs D. S. Foster, J. R. T. Finlayson, I. C. Baxter and Pauline T. Dooley for their kind co-operation.

Dr Dorothy Younie

We apologise for an omission of the formal acknowledgement requested by Dr Dorothy Younie in her paper on *Mental subnormality and the general practitioner*, published in the April *Journal*. This acknowledgement should have been to a comprehensive multidisciplinary study which formed the basis of the material selected for her paper and this will be published under the title *Total Ascertainment of Mental Subnormality in North East Scotland.*

Obituaries

THE HON. ERMINE MARY KYFFIN EVANS

With the death of Mrs Ermine Evans the College has lost its first benefactress. There is the old childhood fantasy of the good fairy in attendance at the moment of birth, the fairy godmother whose influence remains to help the child grow up. Mrs Evans played that role for us. The Steering Committee met and worked at her house in London, No. 7 Mansfield Street, and it was there, on the evening of 19 November 1952 that a handful of signatures on a legal document brought the College to life.

The tradition goes on that the child receives a gift. What more appropriate gift for an infant college than the learning and scholarship of a library? The Geoffrey Evans library at the College, that we know today to be unique among the libraries of the world, was her gift, in memory of her late husband.

The continuing interest in the growth and maturing of the child is vested in her son Ancrum Evans who has served the College as its auditor since the foundation. We have, indeed, good reason to extend our sympathy to him and to his family in their loss, which is also ours.

FRANK GEORGE HOWARD WATSON

M.R.C.G.P., D.Obst.R.C.O.G., D.G.O., L.M. (Rotunda)

Dr Howard Watson, general practitioner in Salisbury for the last 30 years died on 8 May 1975, aged 58.

Frank George Howard Watson was born in Edinburgh on 5 April 1917. The son of a doctor he was educated at Epsom College and St Mary's Hospital Medical School where he qualified in 1942. He joined up immediately and served as a Surgeon Lieutenant in H.M.S. Belfast, taking part in several Russian convoys. After the war he took the D.G.O. (Dublin), L.M. (Rotunda) and the D.Obst.R.C.O.G., and joined a well-established practice in Salisbury. His interest in obstetrics led to his appointment as Assistant Obstetrician at Salisbury Infirmary.

Medical Officer to a local Preparatory School, he was a Member of the Medical Officers of Schools Association, Local Medical Officer to the Civil Service, and Civilian Medical Practitioner to H.Q. Southern Command (now H.Q. U.K.L.F.), a founder member of Salisbury Medical Society. He was an active member of the British Medical Association and held most of the offices of the Division, including that of Secretary. His membership of the Wiltshire Local Medical Committee and the Salisbury Group Hospitals Management Committee took much of his time. He was a founder member of Salisbury Round Table.

Howard had the qualities of a good doctor which gained the respect of his colleagues and the affection of his many patients. He did much more for them than was medically necessary. He never seemed rushed. A good listener and a wise counsellor, he continued to give himself to his work until he was physically unable to continue.

He first developed symptoms of syringobulbia about ten years ago, but steadfastly ignored them, never complaining about his increasing discomfort and disability. His courage and patience were an example to us all. As a partner he was a wise and steadying influence and the loyalty and affection of his staff is further tribute to his qualities.

His love of fishing gave him much pleasure, especially in Ireland where he had built a cottage for his retirement. He was fond of sailing and a keen shot.

He was sustained throughout his long illness by his devoted wife, June. They have three children; Hazel a doctor, Jenny a State Registered Nurse, and John a naval architect.

R. C. HAMBER

CORRESPONDENCE

WHY PRESCRIBE ANTIBIOTICS FOR ALL SORE THROATS?

Dr M. T. Everett suggests (May *Journal*) that prescribing antibiotics for all cases of tonsillitis at the time of presentation is the policy most suited to general practice. He supports this recommendation because it is safe to do so, it may shorten the illness, and it lowers the risk of local complications. He admits that the drawback is the unnecessary use of antibiotics and suggests that there are unlikely to be significant side-effects from this.

Upper respiratory tract infections (including pharyngitis and tonsillitis) are a major health problem. This is not because they are serious medical problems in themselves, but because they are extremely common. Most people experience between one and four episodes of this illness each year and it is often brought to the medical profession to treat. In a two-week period 12 per cent of adults had a sore throat and most of these treated the sore throat without recourse to a doctor (Dunnell and Cartwright, 1972).

According to Wannamaker (1972) pharyngitis is a disease of largely unknown aetiology. The significance of finding a growth of β haemolytic streptococci from a throat swab is unknown unless there is an associated rise in the antistreptolysin titre; about half of all β haemolytic streptococcal "infections" are thought now to be non-infections, the patients are simply carriers of streptococci, the illness being due to a virus or some other agent.

Many authors have tried to associate a specific clinical picture with a specific micro-organism and all have shown (as did Everett) that there is a very poor correlation between symptoms and signs and a causative organism. Most, however, agree with Kaplan (1971) that tender anterior cervical adenopathy appears to correlate best with a β haemolytic streptococcal infection and an antibody response.

Brumfitt and Slater (1957), whose findings are quoted by Everett, divided their patients with streptococcal throats into two groups; one group being treated with penicillin by injection, the other being given non-specific therapy. In this latter group only 16·7 per cent showed a rise in ASO titre; therefore one must question how many of these patients who were treated with penicillin were in fact suffering from a true streptococcal illness. The fact that the treated group improved 24 hours earlier than the untreated therefore means very little as many of the so-called streptococcal infections were probably viral infections in streptococcal carriers.

In larger general-practice surveys Chapple *et al.* (1956) and Merenstein and Rogers (1974) found that penecillin therapy shortened both viral and streptococcal infections when compared with a placebo, but Evans and Dick (1964) found that there was no evidence that penicillin shortened the clinical course of either streptococcal or non-streptococcal illness. Gordon *et al.* (1974) also were unable to demonstrate that antibiotics relieved symptoms and signs more quickly than placebo in acute minor respiratory infections in children.

What evidence there is suggests that penicillin may shorten the illness of some forms of upper respiratory infection and so far there is little definite evidence to suggest which patients to treat and which to leave.

What of those patients who do not come to the doctor? Valkenberg *et al.* (1971) calculated that only nine per cent of patients suffering from a streptococcal sore throat visited a doctor. What of the rest? Are they to be encouraged to visit the doctor so that their illness is shortened, or perhaps penicillin ought to be available for self-medication?

It seems that when one deals with a disease of unknown aetiology that has so many varieties it is little help to draw dogmatic conclusions from relatively small numbers of patients. This is particularly so with a disease complex where about 90 per cent of the people suffering from this illness do not even bother to seek medical advice.

Surely the important question for general practitioners is not "what is the appropriate medication for this sore throat?" but "why did this patient bother to come to consult me and not treat himself as the other 90 per cent have done?" Could it be that there is a more important problem being presented, that this patient's "threshold" is lower than others or that this variety of sore throat is "worse" than others that are not brought?