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.

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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?

What is equally important, in my opinion, is whether any particular clinical picture (for example purulent tonsillitis and fever) responds more quickly to penicillin than to placebo. I suspect it does and I hope that Dr Everett, on looking through his findings will be able to support whether this is so or not.

In my opinion the uncritical prescribing of penicillin for all sore throats will result in poor medical care and needless prescribing with the resultant increased cost to the National Health Service, the risk of sensitivity reactions and the expectancy of the public for treatment by a drug that has not been proven (to my satisfaction) to have any definite effect on their illness.

The more one investigates this vague syndrome of upper respiratory infection the more questions are posed. I would like to see a large (possibly faculty) investigation being organised by the Royal College of General Practitioners to attempt to answer some of the very important questions that general practitioners have to face every working day.

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WORLD CONFERENCE ON GIFTED CHILDREN

Sir,

Might I draw my profession's attention to this problem, please? It is possible that few doctors understand it. The current estimate of gifted children in the community is 200,000. They are the ones, who, if considered compassionately, and cherished, will form the mainspring in the renaissance of Britain from its present parlous state. At present Israel, Russia and some parts of the United States of America, organise special care in the handling of gifted children.

In the United Kingdom, a gifted child is lucky indeed if he is even spotted—there is so much effort devoted to the retarded, that the gifted are neglected and missed. They are, basically, just as much handicapped (being children requiring exceptional treatment) as the retarded. The trouble is that they appear, often obnoxious, precocious, tend to have bad handwriting, and are frequently rebellious because of frustration. It is easy for them, if unrecognised, to become delinquent—or to retreat into a permanent non-productive shell, hiding their talent. The point is to spot them as early as possible (i.e. the " alert baby ") and try, when asked, to be able to guide them and their parents in the management of their difficulties.

There is (during September 8–12) a *World Conference on Gifted Children* to be held at the Royal College of Surgeons, Lincoln's Inn Fields, London. All medical men are welcome. The conference fees are reduced, and a daily rate of attendance can be obtained, to those who are a member of the National Association for Gifted Children, 27 John Adam Street, London WC2N 6HX (annual subscription £2·00). There are branches all over the country.

A generalised awareness by our profession, with observations on how to recognise the gifted, is much needed. A whole morning session at the Conference is devoted to their emotional disturbances for instance. How should we deal with them?

Our College is concerned, primarily, in the promotion of good general practice, which means that each of us should *really* know our patients. The gifted child potentially sets a problem, almost certainly in every general practice. In addition, the subject is inherently fascinating especially as a ' whole-family-problem ', and one in which, with but little trouble, a sympathetic general practitioner can be of immense value.

In the sixteenth century, Queen Elizabeth recognised the problem, and encouraged the gifted. Why not us?

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CHANGES IN THE ENVIRONMENT— AN EPIDEMIOLOGIST'S VIEW

Sir,

I am writing about the final paragraph *The Challenge for the Future* in Sir Richard Doll's excellent and thought provoking article in the May *Journal*.

He says we have to control our appetites for concentrated food, and mental stimulation by drugs and dangerous driving. Surely the best long term way of controlling this is through health education in schools. Attitudes to life are formed in childhood, a fact which is being realised more and more by enlightened teachers in our schools.