

already as much as principals, there is much that remains to be done. Meanwhile a practical start can be made by every local practitioner by insisting that general practice does have a section of its own in the local postgraduate centre, and that every postgraduate medical centre and hospital library does have books about general practice up to at least the same number and value as medicine or surgery.

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Sorry it happened

THE Social Survey Division of the Office of Population Censuses and Surveys has recently published the results of a big survey of contraceptive services carried out by Margaret Bone for the Department of Health and Social Security. This study compares in detail the trends in use of contraceptive services during the last ten years giving special attention to the period 1970 to 1975.

Considerable changes have been detected despite the relatively brief period covered and the fact that the second of the studies was carried out before the introduction of free contraceptive advice within the NHS in 1975.

The trends show that from 1967 there was a steady increase in the use of contraceptive services and that by 1975 about two thirds of all married women were making use of them. Furthermore, at least half of the wives of manual workers were using the service by this date.

In an interesting chapter on social class, comparisons are made between the reactions to the last pregnancy by patients in different social class groups. It has been known for a long time that social class is one of the main determinants of the use of health services, especially contraceptive services, and these figures make interesting reading.

Table 12.5 indicates the reactions to the last pregnancy in which the women surveyed were given a choice of five categories in which to express their feelings. These were: "Pleased, Wished it had happened earlier, Wished it had happened later, Sorry it happened, and Other".

As many as 24 per cent among all patients in social classes four and five in 1970 replied "Sorry it happened"—surely one of the most tragic health statistics of all. Moreover, this figure may well be an underestimate, as it is possible that at least some

mothers might be embarrassed about disclosing their regret to an outside observer.

As medical and social paediatric care become increasingly aware of the importance of warm and loving relationships and the impact these can have on developing children, the proportion of mothers reporting that they were "pleased" at having their baby becomes a critical index of one of the most important factors of all affecting child development. For whatever the technical skill, warmth, or compassion shown by doctors to children, and however elaborate the acts of Parliament and organization of social service departments, nothing can ever quite make up for parents who start child-rearing with some significant regret.

It is a tremendous success for contraceptive services, and especially for general medical practice, that there have been substantial changes in the proportions of women reporting themselves "pleased" at their most recent pregnancy, rising for example from 58 per cent in 1970 to 70 per cent in 1975, and of special importance is the rise from only 52 per cent in 1970 to 62 per cent in 1975 among mothers in social classes four and five. Simultaneously the "Sorry it happened" group in classes four and five has fallen from 24 per cent in 1970 to 17 per cent in 1975, which is statistically highly significant.

These simple figures provide objective evidence of one of the main health care revolutions in modern medicine. As general practitioners become increasingly involved in health education and practical preventive medicine, it is logical that contraceptive care through general practice will be increasingly accepted as a main plank of family care. Advising the family about the number of its members is fundamental.

The latest figures show that over two million women are now registered with general practitioners for contraceptive care, and general practice is clearly

SEPTRIN—for success 9 times out of 10.
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SEPTRIN is effective against all the major pathogens, including *H. influenzae* and *Strep. pneumoniae*.

¹Data on file.

PRESCRIBING INFORMATION

Indications

Bacterial infections of the lower respiratory and urinary tracts, sinusitis, otitis media, skin infections, gonorrhoea, septicaemia, typhoid and paratyphoid fevers, and other infections caused by sensitive organisms.

Dosage

Septrin Tablets and Septrin Dispersible Tablets

Adults and children over 12 years: 2 twice daily.

Maximum dosage for particularly severe infections: 3 twice daily. Minimum dosage and dosage for long-term treatment (more than 14 days): 1 twice daily.

Children 6-12 years: 1 twice daily.

Septrin Dispersible Tablets should be taken in a little water or swallowed whole.

Septrin Adult Suspension

Adults and children over 12 years: 10ml twice daily.

Septrin Paediatric Suspension

Children 6-12 years: 10ml twice daily.

6 months to 6 years: 5ml twice daily.

6 weeks to 6 months: 2.5ml twice daily.

Septrin Adult and Paediatric Suspensions may be diluted with Syrup BP.

In acute urinary tract infections *Septrin* should be given for a minimum of 7 days, in other acute infections for a minimum of 5 days.

Adverse Reactions

Occasionally, nausea, vomiting, glossitis and skin rashes may occur with normal doses and very rarely, haematological reactions.

Precautions

In cases of renal impairment a reduced dosage is indicated and an adequate urinary output should be maintained. Regular blood counts are necessary whenever long-term therapy is used. Caution is advised in patients with folate deficiency.

Contra-indications

Septrin is contra-indicated in patients with marked liver parenchymal damage, blood dyscrasias or severe renal insufficiency. *Septrin* should not be given to patients hypersensitive to sulphonamides; should not be given during pregnancy or to neonates.

Presentation

Septrin Tablets and Septrin Dispersible Tablets each contain 80mg Trimethoprim BP and 400mg Sulphamethoxazole BP.

Septrin Adult Suspension contains 80mg Trimethoprim BP and 400mg Sulphamethoxazole BP in each 5ml.

Septrin Paediatric Suspension contains 40mg Trimethoprim BP and 200mg Sulphamethoxazole BP in each 5ml.

Septrin Paediatric Tablets each contain 20mg Trimethoprim BP and 100mg Sulphamethoxazole BP.

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established as the main source of this care. Future figures are likely to be even more encouraging because the whole of this study was conducted before general practice provided contraception within the NHS, free of charge at the time to the user.

This valuable survey by Margaret Bone is well worth reading, particularly since it shows that social class differences are diminishing in this aspect of medicine if in no other. The Government and the medical profession can be congratulated on agreeing to work in partnership by extending the NHS and providing an important service in increasing numbers to those families in our society who need it most.

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Effect of alcohol (ethanol) administration on sex-hormone metabolism in normal men

To determine whether ethanol in itself affects testosterone metabolism, alcohol was administered to normal male volunteers for periods of up to four weeks, resulting in an initial dampening of the episodic bursts of testosterone secretion followed by decreases in both the mean plasma concentration and the production rate of testosterone. The volunteers received adequate nutrition and none lost weight during the study, which tended to exclude a nutritional disturbance as the cause of the decreased testosterone levels. The changes in plasma luteinizing hormone suggested both a central (hypothalamus-pituitary) and gonadal effect of alcohol. In addition, alcohol consumption increased the metabolic clearance rate of testosterone in most subjects studied, probably owing to the combined effects of a decreased plasma binding capacity for the androgen and increased hepatic testosterone A-ring reductase activity. These results indicate that alcohol markedly affects testosterone metabolism independently of cirrhosis or nutritional factors.

Reference

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