

2. Trainees would no longer be faced with the dual pressure of studying for an examination and finding a partnership.

3. The College would no longer be seen by trainees as threatening, and they would therefore be better motivated to support and influence its activities locally, hopefully as Associate Members.

4. Educationally, vocational training would be seen for what it should be—a time to initiate one's lifelong learning habits—and not, as it is now becoming, merely preparation for an examination, however carefully evaluated the examination is.

5. On the other hand, the prospect of the examination might further motivate young principals towards some form of continuing education.

6. Training schemes would be encouraged to develop their own internal forms of assessment, to their great educational benefit (Stevens, 1974).

No doubt it seemed logical at a time when training schemes were few and trainees all highly motivated to allow those trainees the chance of sitting the College examination before becoming principals. Now that the situation has been made quite different by mandatory training and intense competition for partnerships, the College should think again.

TONY BOND AND 11 TRAINEES
ARCHIE EWING
MALCOLM SADLER
Course tutors
PAUL SACKIN
Course Organizer

Peterborough District Hospital
Thorpe Road
Peterborough PE3 6DA.

Reference

Stevens, J. (1974). Brief encounter. James Mackenzie Lecture, 1973. *Journal of the Royal College of General Practitioners*, 24, 5-22.

Hand, Foot and Mouth Disease

Sir,

We feel it might be of interest to compare findings of a similar outbreak of hand, foot and mouth disease (HFMD) during the same summer in a rural practice 50 miles from that described by Drs Mukherji and Maclean (June *Journal*, pages 366-368).

A total of 14 cases, 12 female and two male, were identified as having features of HFMD. The age range was from 17 months to 13 years. The dura-

tion of the epidemic was three weeks only in June and July 1980. An attempt was made to swab vesicles in all patients, but Coxsackie A16 virus was found in only two cases and, interestingly, herpes simplex virus in one. Unlike Mukherji and Maclean, we found that only five out of 14 cases had any prodromal symptoms—a mild pyrexia with irritability. In all our cases, the onset of disease was characterized by the symptomless appearance of small vesicles, usually first on the buccal mucosa as shallow greyish ulcers with a hyperaemic surround. Within 24 hours the vesicles had appeared either on the hands, feet or buttocks or, in some cases, on all three sites. The shortest duration of illness was five days, and it was found that the hand vesicles tended to clear first. Buttock vesicles (eight cases) tended to be the most persistent lesions, in one case for at least 14 days.

There were some differences between our own small series and that of Drs Mukherji and Maclean, the epidemic in our rural area being apparently much shorter than that in the city. The age range and sex incidence of our patients was also somewhat different from that previously described. Of course it is impossible to draw firm conclusions from such small numbers.

We wonder what is the position of the College Epidemiology Reporting Unit in such epidemics? Surely in relatively uncommon conditions like HFMD, an active approach by this unit to interested general practitioners at the start of the epidemic would be a useful means of generating worthwhile data, the collection of which we found fascinating and potentially very rewarding.

JAMES A. GRANT
BRIAN J. SPOULE

Group Practice Centre
Auchterarder
Perthshire PH3 1AJ.

We showed the above letter to Dr D. L. Crombie, Director of the College's Birmingham Research Unit, who replies as follows:

If the Birmingham Research Unit receives notice from any source of a possible epidemic of this kind, then a special request can be added to the normal weekly return form. In this case the unit was unaware of the presence of hand, foot and mouth disease until the epidemic was virtually over. The chances that one of the 42 recording practices in the weekly returns system will themselves have cases may not be high in the initial phases. I am grateful

for the opportunity to remind your readers that the reporting of their suspicions to us is important: the earlier the better.

Antibiotics in General Practice

We publish the following lengthy correspondence because it illustrates how practice and personal policies can change when we are challenged.

Sir,

I read the editorial (April *Journal*, pages 205-210) with considerable interest, disappointment and not a little frustration. Perhaps the problem lay in the attempt to encompass a very broad topic in one brief article, albeit accompanied by a bibliography of truly legendary proportions.

I wish to take issue with the learned contributor on the proportion of acute infections caused by *Mycoplasma pneumoniae* and its implications for rational therapy. *M. pneumoniae* (not *Strep. pneumoniae*) is the most common cause of acute respiratory disease in general practice (Krech *et al.*, 1976; Mardh *et al.*, 1976) and perpetuation of the time-honoured approach of not giving antibiotics until lobar consolidation is evident will condemn many people to an unpleasant and lengthy illness which is entirely unnecessary. We are advised by the author of this article not to prescribe antibiotics unless there are abnormal chest signs, yet by the time the patient with a mycoplasma infection has a few crepitations audible on auscultation of his chest, an x-ray will show the presence of widespread infiltration of one of more lobes of one or both lungs. How can we justify the continuation of such an approach? This attitude will lead to lengthy and totally unjustifiable delays in diagnosis.

A short while ago (McSherry, 1981), I suggested that it was entirely reasonable to prescribe antibiotics to patients who were ill with acute respiratory disease, even in the absence of focal chest signs. Can anyone explain to me why it is so good for our patients to become very ill before anything is done for them?

JAMES A. MCSHERRY

Student Health Service
Queen's University
Kingston, Ontario
Canada K7L 3N6.