

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.

References

Krech, U., Price, P. C. & Jong, M. (1976). The laboratory diagnosis and epidemiology of *Mycoplasma pneumoniae* in Switzerland. *Infection*, **4**, 33-36.
 McSherry, M. A. (1981). Why not prescribe antibiotics for 'heavy colds'? *Journal of the Royal College of General Practitioners*, **31**, 49.
 Mardh, P. A., Hovelius, B. & Nordenfelt, E. (1976). Incidence and aetiology of respiratory tract infections in general practice. *Infection*, **4**, 40-48.

We showed Dr McSherry's letter to a member of the Editorial Board, who writes:

The crux of our problem with Dr McSherry is that none of us has seen the references on which he bases his case. I understand that the journal he refers to is not held anywhere in this city and we have suspicions that it may, in fact, not be an English-language journal. I think it would be reasonable to ask Dr McSherry to send us photocopies of the papers he refers to to allow us the opportunity to judge whether the strength of his case is such that he should be given a further opportunity to put his point of view. On the whole I think all letters should be published as a matter of principle, as selection tends to create the impression that we are suppressing freedom of expression. If you were able to get hold of a photocopy of this article I would be delighted to read it and comment further on this debate.

We also showed Dr McSherry's letter to the writer of the editorial, who lives a long way from a university library and who replied:

I think Dr McSherry must be taking issue about the treatment of pneumonia, but I find his terminology confusing. In his letter the term 'acute respiratory illness' seems to relate to major chest infection, but in his *Journal* paper the term seems loosely applied to both pneumonia and simple respiratory illness. It is also paradoxical that in his paper he advocates tetracycline or erythromycin for adults, while the incidence of *Mycoplasma pneumoniae* is unquestionably more common in children.

In order to clarify woolly thinking:

1. *Simple respiratory illness in children* (i.e. upper respiratory illness or URTI). One GP saw 724 consecutive illnesses in 12 months and 66 developed bronchitis and four pneumonia, giving a 9.7 per cent incidence of chest infection. The need was acknowledged that sometimes antibiotics have to be given in the absence of chest signs if the cough is 'bad' or chesty (Everett, 1981).

Conclusion: no justification for routine antibiotic use on the basis of the incidence of complicating chest infection.

The commonest cause is surely viral, owing to the wide range of viruses in this type of illness shown by Blair and colleagues (1970), Hobson (1973), Wilks (1973) and Higgins (1974). *M. pneumoniae* was suggested as a common cause by Salinsky (1978), but he gave no proof. Fransen and colleagues (1969) did complement fixation tests (CFT) in 530 patients of all ages with "acute respiratory illness without pneumonia" and found 4 per cent with *M. pneumoniae*. Conclusion: *M. pneumoniae* is apparently not a common cause of simple respiratory illness.

But Foy and colleagues (1979) state that in epidemics of *M. pneumoniae*, many have relatively mild disease, e.g. cough and/or sore throat, and the 5-14-year-old age group particularly develop pneumonia. Conclusion: there could be justification during an epidemic of *M. pneumoniae* to give routine tetracycline or erythromycin to children and teenagers with colds and coughs, as a means of preventing pneumonia or treating early unsuspected pneumonia.

2. *Flu-like illness in adults* (equivalent to simple respiratory illness in children). One GP saw 280 consecutive illnesses in a two-year period: 143 had CFT, many viruses were identified and only one instance of *M. pneumoniae*. Antibiotics used selectively for respiratory complications (Everett, 1977). Conclusion: incidence of *M. pneumoniae* low. No evidence to support routine antibiotic use.

3. *Major chest infection* (pneumonia, acute bronchitis, pleurisy). I agree that the incidence of *M. pneumoniae* as a cause of pneumonia is about 20 per cent (quoted references, plus Fransen, 1969; Foy et al., 1970; White et al., 1981) and that the incidence is highest in children, teenagers and young adults, and that during an epidemic the incidence may be higher than 20 per cent. Conclusion: *M. pneumoniae* is the commonest identifiable cause by CFT, but not the commonest cause.

Streptococcus pneumoniae is believed to be the commonest cause (several references), and in the community Oseasohn and colleagues (1978) found that most instances of radiologically confirmed pneumonia were associated with pneumococci. Hence my advocacy of amoxycillin first. A change to tetracycline or erythromycin need not wait for serology, but can be made after a few days if response is poor (the brevity of the editorial precluded comment on such finer points of management).

The argument against the initial use of tetracycline is that *M. pneumoniae* pneumonia is indistinguishable clinically and radiologically, and it could be inadvisable to use tetracycline for what might be pneumococcal pneumonia owing to the known 13 per cent resistance rate (Ad hoc Study Group, 1977). But erythromycin could be used (no one would argue with that, since it is active against *Streptococcus pneumoniae* and *M. pneumoniae*). This point was made originally in the editorial but was lost in the interests of space).

I agree that sometimes treatment has to go ahead in the absence of physical signs (the editorial does say this), because in both children and adults with pneumonia, chest signs are occasionally absent.

I disagree with Dr McSherry's views on the severity of *M. pneumoniae* pneumonia. My own cases have not been severely ill and did not have a prolonged convalescence, and behaved like any other pneumonia. (Two received antibiotics which included neither tetracycline nor erythromycin, and got better before serological diagnosis—they presumably recovered spontaneously.)

References

Ad hoc Study Group. (1977). *British Medical Journal*, **1**, 131-133.
 Blair, W. et al. (1970). *Journal of the Royal College of General Practitioners*, **20**, 27-31.
 Everett, M. T. (1977). *Practitioner*, **219**, 699-711.
 Everett, M. T. (1981). *Practitioner*, **225**, 379-391.
 Foy, H. M., et al. (1970). *Journal of the American Medical Association*, **214**, 1666-1672.
 Foy, H. M. et al. (1979). *Journal of Infectious Diseases*, **139**, 681-687.
 Fransen, H. et al. (1969). *Scandinavian Journal of Infectious Disease*, **1**, 91-98.
 Higgins, P. G. (1974). *Journal of Hygiene (Cambridge)*, **72**, 255-264.
 Hobson, D. (1973). *British Medical Journal*, **2**, 229-231.
 Oseasohn, R. et al. (1978). *American Review of Respiratory Disease*, **117**, 1003-1009.
 Salinsky, J. V. (1978). *Clinical Trials Journal*, **15**, 76-81.
 White, R. J. et al. (1981). *Thorax*, **36**, 566-570.
 Wilks, J. M. (1973). *Journal of the Royal College of General Practitioners*, **23**, 776-782.

A week later the editorial writer sent a further note:

I now have photostats [Editor: from the College Library] of the two papers he referred to. Mardh and colleagues (1976) acknowledge that viruses are the commonest cause of simple (upper) respiratory illness, but wish to emphasize the unrecognized incidence of *M. pneumoniae*. They give a figure of 16 per cent, but this has to be taken with a