uncomplicated viral hepatitis patients with a high E.S.R. are likely to be of the short incubation period type.

Giles and her colleagues[6] found that in about one-third of their patients the antigen could only be demonstrated during the incubation period, so that it is possible that patients with a low E.S.R. who are antigen-negative by the double-diffusion test may be of the long incubation period type. Further investigation is necessary, using more sensitive tests, to show whether this is so. Krugman *et al.* found that the thymol turbidity test was usually normal in the long incubation period type and high in the short incubation period type.[1] These findings, and those of the E.S.R., could be explained by changes in the serum proteins.

Most laboratories are unable to do the simple double-diffusion test because of the scarcity of the specific antibody. The E.S.R. can be done in all types of hospital and it is hoped that may prove an additional help in the differentiation of the two types of viral hepatitis.—I am, etc.,

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1 Krugman, S., Giles, J. P., and Hammond, J., *Journal of the American Medical Association*, 1967, **200**, 365.
2 Cossart, Y. E., and Vahrman, J., *British Medical Journal*, 1970, **1**, 403.
3 Dacie, J. V., and Lewis, S. M., *Practical Haematology*, 4th edn. London, Churchill, 1968.
4 Blumberg, B. S., Melartin, L., Guinto, R. A., and Werner, B., *American Journal of Human Genetics*, 1966, **18**, 594.
5 Giles, J. P., McCollum, R. W., Berndtson, L. W., Jr., Krugman, S., *New England Journal of Medicine*, 1969, **281**, 119.

Trichomonas and Oxytetracycline

SIR,—I wish to report the case of a 66-year-old female patient whom I first saw during the course of a geriatric domiciliary visit. Having just recovered from an episode of acute on chronic bronchitis, she was still taking oxytetracycline 250 mg four times daily, as prescribed by her general practitioner. She was on no other treatment.

I found the course of her recovery satisfactory and was about to leave when she confided that she was considerably bothered by pruritus vulvae together with vaginal discharge. She refused hospitalization previously when she was being treated for bronchitis, and again in this case she would not go to a gynaecological clinic. In view of this I re-visited her, armed with Cusco's speculum, microscope slides, and three different culture media (Stuart's Sabouraud's, and Feinberg-Whittington).

These investigations resulted in the bacteriological diagnosis of a trichomonal vaginitis, for which metronidazole 200 mg three times daily for one week was prescribed. Follow-up examination ten days later showed no improvement, and the Feinberg-Whittington medium yielded a positive culture again. By this time her lungs had cleared completely and so it was possible to stop treatment with oxytetracycline while repeating a week's course with metronidazole. Two further follow-up tests showed complete clearance of her discharge together with negative bacteriological tests.

The first interesting point emerging from this case is that the possibility of the infection being sexually transmitted could be ruled out with certainty. The second point is even more interesting as it would appear that oxytetracycline and metronidazole might show therapeutic antagonism with regard to the latter agent's effect on the protozoon *Trichomonas vaginalis*. This combination of oxytetracycline with metronidazole must be a common occurrence in venereology and gynaecological clinics, considering the frequency of mixed infections.

I wonder if any of your readers could confirm or refute the validity of my hypothesis, based on chance observation.—I am, etc.,

STEPHEN SZANTO

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What Price Fellowship?

SIR,—Most of my medical colleagues have received from the Royal Society of Health invitations to become Fellows of the society.

The invitations, whose style seems inspired more by Madison Avenue than by a royal society's secretary, amount to little more than offers to sell the letters F.R.S.H., for use after one's name, in exchange for $21 per annum. They do, however, have slightly more style than comparable "mail order" degrees from one-room California colleges or divorces from a Mexican border town. While the invitations cause considerable amusement and several talking points, the derision that they cause spreads, so that I have already admitted to my colleagues that I only paid slightly more for my fellowship of a royal college.

I realize that invisible exports are a vital part of the economy, but there must surely be less demeaning ways of attracting dollars into the country. I cannot imagine that the president of the Royal Society of Health disagrees with this point of view.—I am, etc.,

NEVILLE ROSEN

Lawrence, Massachusetts,
U.S.A.

SIR,—The multiplicity of initials that British doctors have after their names is a source of confusion and envy to my North American colleagues. Sensibly, they have limited their credentials to the letters M.D., but there can be no doubt that many of them crave the royal flavour of additional letters after their names.

One organization which sets out to take advantage of this trait is the Royal Society for the Promotion of Health, which has recently circularized some of my house officer friends here, asking them to allow their names to be put forward for election to the fellowship of this society "because of their professional status" and "carrying the designation F.R.S.H.". With their application they are told to send in a subscription of $21 so that they may join "the largest organization of its kind in the world".

My colleagues have sought my advice as to the significance of these initials, imagining that they carry the same weight as the M.R.C.P. or F.R.C.S., and obviously many American physicians have been attracted, for another 5,000 of them belong to this society. The president of the society advertising in this fashion is Lord Cohen of Birkenhead, president of the General Medical Council.—I am, etc.,

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Backache

SIR,—Mr. G. V. Chamberlain in his article entitled "Backache—II" (17 April, p. 159) deals very adequately with the increased strain on the back joints and the ligaments which guard them, in the section on pregnancy and its after effects. However, I feel his treatment of bed rest and exercises is defeatist, as in most of these women the backache in pregnancy is due to the lax ligaments allowing the facet joints to become deranged. The treatment of this is a simple specific manipulation, without an anaesthetic, of one of the lumbar facet joints, or of the sacroiliac joint itself. The fact that this condition can be cured by one or two very gentle specific manipulations of the lumbar facet or sacroiliac joints without an anaesthetic does not appear to be widely enough known.

In my experience such procedures have no adverse effect on the pregnancy.—I am, etc.,

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Chemotherapy of Bronchitis

SIR,—Tetracyclines have been used in the treatment of bacterial infections of the respiratory tract, especially pneumonia and bronchitis (17 January 1970, p. 125). Pneumococci resistant to tetracyclines have been widely encountered and a high incidence of such strains has been reported recently from Liverpool.[1] Tetracycline-resistant strains of *Haemophilus influenzae*, another important respiratory pathogen, have been less frequently seen and we know of no record of resistance among capsulated strains. We wish to report the isolation of a strain of *Haemophilus influenzae* type B resistant to tetracycline from a patient with postoperative respiratory infection.

The patient was a woman aged 27 years who developed fever (39·5°C) and cough with mucopurulent sputum about 11 hours after tubal ligation; a specimen of sputum yielded a marked growth of *Haemophilus influenzae* type B. There was no record of recent tetracycline therapy. She was treated with physiotherapy and was well enough to be discharged from hospital after four days.

When tested by the disc diffusion method on heated blood agar the haemophilus was resistant to tetracycline (10 μg per disc) but sensitive to streptomycin (20 μg), erythromycin (2 μg), and ampicillin (2 μg). In a quantitative test by the plate titration method the minimal inhibitory concentration of tetracycline hydrochloride was 25 μg per ml. This degree of resistance would exclude the possibility of effective therapy with tetracycline in normal dosage.—We, are, etc.,

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1 Percival, A., Armstrong, Elizabeth C., and Turner, G. C., *Lancet*, 1969, **1**, 998.

Tick-borne Typhus in England

SIR,—I read with interest a report of African tick typhus in your Epidemiology section (23 January, p. 240). The patient was an