the days of the week down one side and four columns alongside so that the appropriate square could be ticked when the dose was taken. This would provide patient and doctor with a handy visual check on drug compliance. On the back of the card could be printed details of any important side effects or contra-indications.

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Preventing infective endocarditis

SIR,—Your leading article (17 December, p 1564) is useful in drawing attention to the American Heart Association's latest recommendations[1] on this important subject. It is perhaps regrettable that in Britain we have not managed to publish a similar report.[2] Such a report was, in fact, prepared in mid-1975 and, largely owing to entrenched opinions, has not yet seen the light of day. In the preparation of this report I was in close communication with the American team, and the recommendations arrived at were virtually identical. I would, therefore, commend a study of the American Heart Association's full text to your readers.

Parenteral prophylaxis should be given in all patients with prosthetic valves and those treated in hospital. Your article mentions that the indications for an oral regimen are not clear. These were dealt with in my letter to the *BMJ* in 1975[2] and, in brief, arise from the fact that in this country in general dental practice, oral regimens are already widely used, that dentists will not give intramuscular injections to their patients, and liaison with the patient's doctor to permit injection to be given at the appropriate time is simply not practicable. Furthermore, the work of Pelletier *et al*[3] suggests that a suitable oral regimen is efficiently bactericidal.

Because of the number of cases of infective endocarditis that do not follow a recognisable insult the importance of good conservative dental care cannot be too frequently stressed.

The suggestion in your final paragraph that "a modified technique might either confirm or qualify the conclusions drawn and possibly render the clinician's task less burdensome" seems to me to perpetuate the heavy weather that is made of this subject. Surely we have admirable recommendations before us and we should follow them until better are produced. In the light of present evidence they are "as harmless as possible, and as effective as possible."[4]

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[1] American Heart Association, *Circulation*, 1977, **56**, 139A.
[2] Fleming, H A, *British Medical Journal*, 1975, **2**, 541.
[3] Pelletier, L L, Durack, D T, and Petersdorf, R G, *Journal of Clinical Investigation*, 1975, **56**, 319.
[4] Fleming, H A, *Lancet*, 1976, **1**, 644.

Skateboard injuries

SIR,—I was interested to note the distribution of injuries following skateboard accidents in Dr Cynthia Illingworth's article (24-31 December, p 1636).

Of particular note was the discovery of six fractures of the scaphoid out of 37 patients radiographed. Fractures of the scaphoid in children are very rare and if the incidence of scaphoid fractures in this small series is borne out by larger series it would seem extremely important for this to be brought to the notice of other people seeing skateboard injuries.

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Anorexia nervosa and family therapy

SIR,—Your leading article on anorexia nervosa (7 January, p 5) gives fair mention of the importance of family factors. Many family therapists would want to emphasise the value of considering the family system—the "whole" which is more than the sum of the parts—and the significance of the blurring of the intergenerational boundary.

A family with an inadequate boundary between parents and children may present with symptomatology other than anorexia nervosa, but often where this condition is present the boundary problem seems to be especially relevant and striking. Therapy may be directed towards a strengthening of marital bonds and to a lessening of the emotional over-involvement between child and parents.[1]

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[1] Minuchin, S, *Families and Family Therapy*. London, Tavistock Publications, 1974.

Cough in farmer's lung disease

SIR,—Cough is an important diagnostic feature of farmer's lung disease (FLD).[1] In most accounts, however, it is not stated whether the cough is dry or whether a significant amount of sputum is produced. Parratt *et al*[2] and Grant *et al*,[3] for instance, use the dry cough as one criterion to select their cases of FLD. We think that the productivity of the cough is an important clinical element in the disease.

We have cultured specimens of sputum for the organisms associated with FLD since 1969[4]; the appearance (purulence, etc) of the sputum was also noted. From 1969 to 1977 80 isolations of *Micropolyspora faeni* and 25 isolations of *Thermoactinomyces* spp (mainly *T candidus*)[5] were made. Patients from whom these isolations were made all had clinical FLD; 35 patients (50%) had copious sputum which was frequently purulent. Some of our patients appear to have had FLD for many years although they have avoided contact with mouldy hay. One patient has given up his farm and been a bus driver for the past two years but still produces positive sputum cultures.

We suggest that FLD can manifest itself in two ways, each with its symptomatology and serology. Firstly, FLD can appear as a mild acute illness, with symptoms which include a dry cough, that appears some hours after exposure to mouldy hay. The patients are serologically negative or weakly positive and thermoactinomycetes are not isolated from the sputum. But FLD can also appear insidiously as a chronic disabling disease with profuse purulent sputum and strongly positive serological findings; thermoactinomycetes can readily be isolated from the sputum. We suggest that the first manifestation of FLD is a "primary" sensitivity response and the latter disease process is the product of actual colonisation of the lung by thermoactinomycetes. Plate tests indicate tetracycline sensitivity of the thermoactinomycetes under study and it would seem to be logical to treat the chronic disease with tetracycline.

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[1] Campbell, J M, *British Medical Journal*, 1932, **2**, 1143.
[2] Parratt, D, *et al*, *Clinical and Experimental Immunology*, 1975, **20**, 217.
[3] Grant, I W B, *et al*, *British Medical Journal*, 1972, **1**, 530.
[4] Pether, J V S, and Greatorex, F B, *British Journal of Industrial Medicine*, 1976, **33**, 265.
[5] Greatorex, F B, and Pether, J V S, *Lancet*, 1976, **1**, 1134.

Campylobacter enteritis in Sweden

SIR,—We read Dr M B Skirrow's report (2 July, p 9) with great interest and have adopted his technique for isolating campylobacteria from faeces. Between 15 July and 31 October we have isolated *Campylobacter jejuni* from 15 subjects (13 patients with diarrhoea and two healthy carriers). We can fully confirm previous observations on the severity of the diarrhoea in many cases—four of our patients had bloody stools. Agglutinating antibodies against formalinised suspensions of patients' strains have appeared in most cases.

Most of our patients (eight out of 13) have obviously been infected abroad (Finland, Spain, Great Britain, Tanzania) and in one case we have isolated *C jejuni* from two members of the same family and also from the family dog, which also had an enteritis.

During the 3½ months 17 new cases of salmonellosis, five cases of shigellosis, and six cases of yersiniosis were diagnosed in our laboratory. Campylobacter thus seems to be as common a cause of diarrhoea in Sweden as any of the "established" pathogenic bacteria.

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Hair in the theatre

SIR,—I was delighted to read Dr N A Simmons's letter on the flowing locks of the modern surgeon (14 January, p 111). To those of us old enough to remember the cropped heads of George Perkins and Philip Mitchiner these modern styles confirm what I have long suspected—that the Arbuthnot Lane technique of the '20s and '30s which reduced sepsis in clean wounds to less than 1% has now been lost in an antibiotic euphoria. Recently I heard at a lecture one of the younger surgeons admitting to a sepsis rate of 8% in clean appendix wounds, and from talks with general practitioners who deal with patients discharged from hospitals there appears to be a real feeling of increasing sepsis in clean surgical wounds.

The surgeon's hair, of course, is probably only a minor factor in the problem, but if Dr Simmons's letter marks only the beginning