

total of 13 pregnancies have occurred, in three cases without any additional therapy. Of the 13 pregnancies, 10 have so far resulted in live births, one is continuing, and there was one first-trimester miscarriage and one therapeutic termination. No symptoms of pituitary tumour expansion occurred in any of these implanted patients; visual acuity and visual fields were rechecked and fossa radiographs were repeated without evidence of deterioration.

We would like to point out that the hazards of radiation treatment mentioned by Dr Bergh and his colleagues (references 45-48 dealing with visual loss, brain necrosis, and development of sarcomata) all apply to the use of external irradiation and not, as might be inferred from the text, from yttrium-90 implants.

In summary, we believe that low-dose implantation of yttrium-90 can be regarded as a useful form of treatment in young women with prolactinomas who desire fertility and that tumour expansion in these treated patients is less likely. We are currently preparing a detailed report for publication.

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¹ Von Werder, K, et al, *Journal of Endocrinological Investigation*, 1978, 1, 47.

Safety in laboratories

SIR,—In your leading article (8 April, p 871) your assumption that “there is no evidence that laboratory-acquired infections are still a serious problem in laboratories of hospitals and the PHLS” is based on meagre evidence indeed. During the course of a three-year study of health and safety in British medical laboratories I was astounded at the wide variation in the safety standards obtaining in such laboratories. Hard facts about the occupational risks from common infectious agents are difficult to assemble and have never been adequately compiled. Pulmonary tuberculosis, however, is five times more common in medical laboratory workers than in the general population.¹ We found no evidence of excess mortality from infectious disease, though there did appear to be an excess risk of dying of lymphoma or committing suicide.²

Perhaps more disturbing in view of the ignorance of risks related to common infections were the findings that safety cabinets and centrifuges were rarely serviced appropriately, that 65% of laboratories permitted mouth pipetting, and that the compulsory use of protective clothing for specific purposes was rarely invoked.³ In a prospective study of a random sample of 12% of NHS and PHLS laboratories infective and parasitic diseases were the chief cause of time off work.⁴ This was primarily due to diarrhoeal illness and was significantly in excess of comparable populations working for two large public undertakings not handling infectious material. Regarding accidents resulting in injury, such events affected one in four laboratory workers in the course of a year—mainly due to lacerations to the hands, face, and eyes.⁵

In view of these findings it is surprising that laboratory workers seem to maintain such good health. They certainly seem to be at high risk, inflicting considerable injury upon themselves, and have markedly increased rates of

diarrhoeal disease. Further research is clearly needed, but the current position leaves no grounds for complacency.

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¹ Harrington, J M, and Shannon, H S, *British Medical Journal*, 1976, 1, 759.

² Harrington, J M, and Shannon, H S, *British Medical Journal*, 1975, 4, 329.

³ Harrington, J M, and Shannon, H S, *British Medical Journal*, 1977, 1, 626.

⁴ Harrington, J M, and Shannon, H S, Proceedings of XVIIth International Congress of Occupational Health, Brighton, 1975.

⁵ Harrington, J M, MD Thesis, University of London, 1971.

No-fault liability

SIR,—I would like to congratulate you on your leading article on this topic (1 April, p 805) and commend the matter once again to the BMA for consideration. The BMA gave evidence to Lord Pearson's Royal Commission on Civil Liability and Compensation for Personal Injury¹ and advised against introducing the concept of no-fault compensation for injuries consequent on medical treatment.² However, an article by your legal correspondent shortly afterwards warmly supported it.³

Anaesthetists have a particular interest in this matter: there is quite a spectrum of accidents in which fault is difficult to identify or quantify, and a “forensic lottery” is most unsatisfactory as an element of public policy. The full lessons of an accident may not be learned by the profession at large for a very long time if the facts cannot be publicly admitted because of fears over possible litigation. For these and other reasons, the Association of Anaesthetists of Great Britain and Ireland supported no-fault compensation for medical accidents in its evidence to the Royal Commission. While the commission, having agreed with the BMA, may now feel irked to be castigated for its “disappointing recommendations,” it is heartening to think that opinions may now be changing.

You are also right to draw attention to the problem of compensation for volunteers injured as a consequence of medical research. To restrict compensation to instances where causality can be proved is to exclude a substantial part of the potential problem. It is to be hoped that Lord Pearson's recommendations will be the subject of active and informed debate within the profession. The decision to accept or not accept them could have a most profound impact on medical practice in this country.

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¹ Annual Report of Council, 1974-5, *British Medical Journal*, 1975, 2, 216.

² BMA evidence to the Royal Commission on Civil Liability and Compensation for Personal Injury, 1974.

³ *British Medical Journal*, 1975, 4, 529.

SIR,—It is unfortunate that your leading article “No-fault liability” (1 April, p 805) should repeat the common misconception that since April 1974 the tort of negligence in respect of personal injuries has ceased to exist in New Zealand.

The position is that where a claim in respect of an injury is accepted by the Accident Compensation Commission then the claimant

may not proceed in tort. The court has also the discretion to refer claims to the commission. Cases do arise, however, in the medical as well as in other spheres where the commission rejects the claim on the grounds that it did not arise from an accident as defined in the Act. In such circumstances it remains open for the claimant to sue in negligence so that the situation is that a doctor still requires cover against the risk of negligence actions.

You also tell us that the profession will have to think deeply about the “recommended strict liability for dangerous drugs.” The commission's recommendation is that there should be strict liability for all drugs, which perhaps requires the profession to think still more deeply.

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* * * We did not say that the tort of negligence in respect of personal injuries has ceased to exist in New Zealand. What we said, correctly, is that the right to claim damages for accidental injuries has been abolished. Certainly doctors will still be open to actions in negligence for injuries held not to be accidental and, for example, where negligent failure to diagnose an illness allows it to run its natural course unchecked. Our comment on strict liability for dangerous drugs should have read “for dangers from drugs.”—ED, *BMJ*.

Antibiotic-associated colitis

SIR,—Dr A Kappas and his colleagues at the General Hospital in Birmingham have noted that there appears to be an unusually high incidence of pseudomembranous colitis in their practice (18 March, p 675). This they attribute to improved diagnosis. What they do not appear to have considered, however, is that the use of antimicrobial agents at this hospital may also be unusual. In 15 patients developing pseudomembranous colitis after colorectal surgery a total of 53 antimicrobial agents were used either before or after operation.

The choice and use of postoperative antibiotics are governed by the judgment of the individual clinician, but perhaps the time has come to reappraise the use of prophylactic therapy. The use of preoperative antibiotics is based on the evidence that it leads to a reduced incidence of postoperative wound infection, but there is little evidence that such treatment prevents complications in healing colorectal anastomoses. Abdominal wound infection is rarely a life-threatening problem. Pseudomembranous colitis is a serious problem, and if the prophylactic use of antibiotics in surgical patients is a significant factor in the pathogenesis of this disease I would suggest that it be discontinued.

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SIR,—Your leading article (18 March, p 669) on this topic is both illuminating and timely. If diarrhoea is accepted as the first clinical manifestation of this disorder the latter calls for ever-present vigilance when antibiotics are prescribed, since the incidence of diarrhoea was found to be around 20% in two series of