behind. This method is most useful in patients with tattoos which have been inflicted by the modern method, using transfers and electric needles, as in these cases the penetration of the pigment is not very great. It is important when doing this to make the clearance in one swoop and to do this it is essential that the surgeon should go as deep as possible without actually cutting through the dermis. This is a much quicker method than has been described and a much more satisfactory one. If too superficial a plane has been chosen it is still possible to remove the deeper remnants with dermabrasion.—I am, etc.,

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Allergy to Aspirin

SIR,—We were interested to read in your leading article (27 July, p. 216) on allergy to aspirin the statement that "Aspirin-sensitive asthmatics frequently have nasal polyps, but polypectomy does not alleviate the symptoms or control the asthma."

Polypectomy may certainly relieve the nasal symptoms for a time, but as regards the control of asthma the operation may precipitate asthmatic symptoms which have not in fact been previously overt. We are both familiar with such cases, and indeed one of us (F.D.H.) saw some years ago a man aged 55 years, who had never at any time suffered from asthma previously, develop severe status asthmaticus after polypectomy. His asthma continued variably for some five years until he failed to return to the clinic. A second, rather milder case in a man aged 40 was seen some years later: again, asthma appeared initially in severe form only immediately after polypectomy. —We are, etc.,

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E. H. MILES FOXEN

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Age Limit for Contraceptives

SIR,—Dr. Elizabeth M. Elliott (27 July, p. 260) suggests that the Family Planning Association's "wholehearted support for the decision to impose no age limit on supplies of contraceptives" under the Health Service was a decision which did not have the weight of the F.P.A. clinic doctors behind it. May I point out that there is a perfectly democratic method open to any doctor who does not agree with F.P.A. policy and that is through the F.P.A.'s Clinic Doctors' National Council? Indeed, Dr. Elliott was invited to attend a meeting of the council—comprising her colleagues from all over Great Britain—in November 1972 to discuss her controversial views. She did not attend.

Dr. Elliott continues to work for the F.P.A. and is chairman of one of the branch doctors' groups. If she and her branch doctors agree about any of the points she wishes to make it is open to her to put these up in the form of a resolution to the council. —I am, etc.,

ELIZABETH GREGSON
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F.P.A. Clinic Doctors' National Council

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Diabetic Autonomic Neuropathy

SIR,—Your leading article on this subject (6 July, p. 2) draws attention to the need for tests which are simple and easily performed.

No reference was made to the use of the psychogalvanic response[1]—that is, the change in electric potential between electrodes applied to the skin of a limb that occurs in response to certain stimuli and which is abolished by interruption of the sympathetic pathways. This response is easy to demonstrate at the bedside using an E.C.G. machine.[2] It provides an immediate indication of sympathetic activity in a limb. It has proved particularly useful in diabetics with peripheral vascular disease since there is little advantage to be anticipated in performing a sympathetic ganglionectomy on a patient in whom a neuropathy has already led to sympathetic denervation. The test is also valuable in verifying the success of chemical sympathectomy.

Lentle[3] has investigated the psychogalvanic response in diabetics and found it to be abolished in all his patients with florid neuropathy.—I am, etc.,

GORDON HEARD

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1 Heard, G. E., *British Journal of Surgery*, 1964, 51, 629.
2 Lewis, L. W., *Current Researches in Anaesthesia and Analgesia*, 1955, 34, 334.
3 Lentle, B. C., *The Complications of Diabetes Mellitus*, M.D. Thesis, University of Wales, 1967.

Measurement of Side Effects of Drugs

SIR,—The conclusions drawn by Drs. E. C. Huskisson and J. A. Wojtulewski (29 June, p. 698) go some way beyond the evidence they present and seem in part unjustified. At one of the two centres where their study was performed patients were asked only the non-specific question: "Have you noticed any new symptoms which might be related to the treatment?" At the other centre a check list asking about 21 possible side effects was *also* used (my italics). The authors do not say whether at the second centre the non-specific question was asked before or after the patient was asked the questions on the check list, nor do they compare the answers of the patients to the non-specific question with the *same* patients' answers to the check list questions. Such a comparison would provide a more critical test of the authors' conclusions.

We have compared the results of using non-specific questioning and using a check list in assessing unwanted effects of pentagastrin in medical students.[1] Five, seven, and nine minutes after receiving an injection the subjects were asked whether they felt anything unusual, and only then were they asked specific questions from a check list. Non-specific questioning elicited a total of 31 symptoms in 13 of 15 subjects given pentagastrin and none in those given saline. The check list questions elicited a total of 48 symptoms after pentagastrin (mean three per subject) and nine after saline (mean one per subject).

As in the study by Huskisson and Wojtulewski, each method of questioning elicited a different type of information. The responses to non-specific questions showed a wide range of unwanted effects that seemed noteworthy to the subjects, whereas the check list questions provided a much better estimate of the incidence of those effects that were asked about. The two methods should be regarded as complementary not as alternatives, and it is wrong to conclude that "since check lists increase the incidence of irrelevant complaints they should not be used."—I am, etc.,

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1 Barrowman, J. A., Herxheimer, A., and Kits, T. P., *Clinical Pharmacology and Therapeutics*, 1970, 11, 862.

Kidneys for Transplantation

SIR,—I was interested to note that in the statement on artificial feeding of prisoners prepared by the Central Ethical Committee of the B.M.A. and approved by Council (6 July, p. 52) attention was drawn to the fact that doctors must always bear in mind their obligation to preserve human life.

It is a great pity that this body does not call this obligation to the attention of the hundreds of hospital doctors who continue, either through ignorance, disinterest, or both, to allow viable cadaver kidneys to be lost to the transplant surgeons waiting for the opportunity to save the lives of their patients.

Still in Britain thousands of young lives are lost every year through lack of cadaver kidneys for transplantation, and hundreds are relegated to lives of uselessness and wretchedness on kidney machines. Every week thousands of viable, life-saving kidneys are burnt in crematoria or buried six feet down in graveyards, taking with them the chance of life or rehabilitation to the many young sufferers from end-stage renal failure.

If all doctors would remember their obligation to preserve life, and not just the lives of their own patients, then this tragic situation would come to an end.—I am, etc.,

ELIZABETH WARD
Chairman,
Silver Lining Appeal of the National
Kidney Research Fund

Bordon, Hants

Effects of Posture on Limb Blood Flow in Late Pregnancy

SIR,—The paper by Dr. G. B. Drummond and his colleagues (15 June, p. 587) is most interesting as we are currently involved in a similar study. Their work supports the findings of Eckstein and Marx,[1] who measured blood pressure changes in the upper and lower limb in pregnant patients at term, supine and with uterine displacement. They found a significant decrease in femoral blood pressure in the supine position, while upper limb pressures increased or remained unchanged.

However, I feel the conclusion drawn by Eckstein and Marx from their study applies also to the work of Dr. Drummond and his colleagues. Eckstein and Marx concluded that decreased blood pressure is more indicative of lower aortic obstruction than of lowered cardiac output following vena caval obstruction. This would appear equally relevant to blood flow studies. The term aorta-caval occlusion would therefore appear preferable to vena caval occlusion, in that both the major abdominal vessels are compressed and produce deleterious effects on uterine perfusion—aortic occlusion by direct