The biological test is still far more efficient than the laboratory investigation. It would be helpful if this point could be mentioned in future articles in the press as it would reduce the anxiety among the young women and the pressure on our overworked special clinics.—We are, etc.,

W. HOWARD HUGHES
J. M. DAVIES

Samaritan Hospital for Women,
London N.W.1

Pregnancy Testing

SIR,—Dr. F. W. Winton (30 October, p. 296) has quite reasonably pointed out the excessive demand made on hospital laboratories by people requiring pregnancy diagnosis. This of course is further confirmation of Mr. Enoch Powell's thesis that a free Health Service will inevitably lead to an unlimited demand on that service.

The fact that so many of the requests are for "social" reasons does not mean that they are not valid reasons. So much of the work we do in medicine (including pathology) is not strictly necessary medically, but we do it willingly for some such reason as reassurance of our patients. Most general practitioners are probably happier when patients consult at a stage when pregnancy can be confirmed clinically, but nowadays they seem to present only a few days after they have missed a period—and they expect an answer. This is understandable. Are we to refuse them and possibly allow our rapport with them to suffer?

If we believe in a free Health Service we must expect the demand on it to be almost unlimited, and we must have staff and facilities enough to cope with this demand. If we want the demand to be limited, the only way to do this is, surely, by some financial "deterrent."—I am, etc.,

W. G. BENSON

Exeter

SIR,—As a general practitioner I am in full agreement with Dr. F. W. Winton, a bacteriologist, in his views on pregnancy testing in normal healthy women for non-medical reasons (30 October, p. 296).

In this day and age that these tests are necessary and are frequently requested for social reasons cannot be disputed. Work, holidays, and indeed legal abortion may be very good reasons for making a diagnosis of pregnancy at an early stage. That a hospital laboratory should do these tests is, in my view, a waste of valuable time and is unnecessary and undesirable. In a partnership of two with a not very large list we receive frequent requests for this test. For several years now they have been done in the surgery while the patient waits, either by the practice nurse or by ourselves.

The test costs us 25p per test and the annual expense to the practice is £18. We regard this as a normal practice expense like other simple surgery diagnostic procedures. We would not object, of course, if we were reimbursed by the D.H.S.S.—I am, etc.,

GEORGE GRANT

Jarrow, Co. Durham

SIR,—I do not think that Dr. F. W. Winton (30 October, p. 296) can have any idea of the strong emotion felt by a woman awaiting the result of a pregnancy test. I would question the criteria on which he has divided the reasons for requests for pregnancy tests into "medically acceptable" and "social" grounds. To my mind the only "social" reason for a pregnancy test would be if it were requested by a third party, in the same way that a chest *x*-ray is sometimes requested by a prospective employer or immigration authority. Any pregnancy test requested by a family doctor must have a "patient-care reason." Dr. Winton seems to be unaware that in general practice we are concerned with our patients' hopes and fears as well as the bacteriological and pathological states that he observes in his laboratory.

The question of who undertakes the testing may be at issue. It must be part of the National Health Service, and I hope that whoever does it will realize its importance and not look upon it as an interruption of his real work. To me as a general practitioner the efficient, prompt, and courteous pregnancy diagnosis provided by my local hospital laboratory is an aspect of the National Health Service that gives me great pride and is of the greatest value to my patients.—I am, etc.,

MACPHERSON KNOWLES

Worcester

SIR,—I agree with Dr. F. W. Winton (30 October, p. 296) that pregnancy testing under the N.H.S. could be provided where indicated by general practitioners. I would prefer the test to be carried out at my surgery if the small cost were reimbursed or could be met by the patient. An alternative way around the present disincentive would be the provision of the equipment by executive councils (as with disposable syringes) or by the clinical pathology department of local hospitals (as is already done for containers of specimens)—I am, etc.,

JEFFREY SEGALL

London N.W.2

SIR,—While agreeing with Dr. F. W. Winton (30 October, p. 296) that many pregnancy tests pander to the impatience of the modern woman to know the worst before nature in the shape of a second missed period gives the answer, one must remind him of the extreme urgency of the matter when induction of abortion is contemplated. Without this test how can the general practitioner set in train the elaborate machinery (referral to a psychiatrist or organization of a trip to London or Birmingham) necessary to remedy the unfortunate patient's condition? Then there are the harassed mothers on the pill who miss a period. Social reasons these may be for this test (in my experience the most used of any laboratory procedure) but as valid surely as any if the patient's good is the primary consideration.—I am, etc.,

S. L. HENDERSON SMITH

Huddersfield

Taking Medicines during Ramadan

SIR,—We should be grateful to Dr. N. H. Silverton (23 October, p. 233) for drawing our attention to this important aspect. He has very rightly described the practice of Moslems during this holy month, but let me point out that if the doctor feels that the patient's health is not fit for observing the fast then the patient is not bound to fast from a religious point of view. It has been said in Holy Koran that a person does not become nearer to God by subjecting himself to unnecessary misery. The whole purpose is then lost. In fact disobeying the doctor then would amount to suicide, which is unpardonable. All the women who are having periods or are lactating or any person who is undertaking a long journey or any sick person is not to fast. They should fast later and complete the "course," so to say. Therefore the question of fasting does not arise for anyone who is suffering from acute illness, but for chronic illnesses each case should be dealt with according to its individual merit, in the light of the above. I hope this will be of some help to my colleagues.—I am, etc.,

K. SAYEED AHMED

Bronglais General Hospital,
Aberystwyth

The Ward Sister

SIR,—This committee, in the belief that the National Health Service is for the benefit and treatment of patients, would like to express its concern at the loss of status of ward and outpatient sisters under the present Salmon structure. We consider there is a great need for an improved salary structure and status recognition without the need for such key staff to leave their ward or department.— I am, etc.,

IAN D. HENDERSON
Chairman,
Group Medical Committee,
Tunbridge Wells and Leybourne H.M.C.

Tunbridge Wells,
Kent

Treatment of Bell's Palsy

SIR,—Having myself followed a small number of Bell's palsy cases recently in a relatively unsophisticated trial while at senior house officer grade, it was with great interest that I read the authoritative paper by Dr. D. Taverner and others (2 October, p. 20) comparing the benefits of prednisolone and corticotrophin.

However, I feel several points should be raised. Firstly, the initial five-day course of prednisolone at 80 mg daily seemed too high a dose to compare with 60 units of corticotrophin daily, and I would suggest therefore that the relative benefits conferred by prednisolone were purely dose-dependent rather than due to any specific action of prednisolone. Thus the result of the trial could possibly have been reversed by giving a larger dose of corticotrophin, and ideally the blood level of circulating steroids might have been measured. With the high dose of prednisolone recommended, even in the short term, there must be an increased risk of side effects, especially when used outside the close confines of a therapeutic trial such as this, where aged, hypertensive, diabetic, dyspeptic, and pregnant patients were carefully excluded.

Secondly, it was stated that "the results of earlier treatment were indeed better," whereas 78% of the group in which treatment was commenced on the third and fourth day (94 out of 120) recovered completely as compared with only 71% of those

where treatment was started on the first and second day (47 out of 66).

Thirdly, though great detail was given, no mention was made concerning the sex of the patients. In my own limited collection of 19 cases, all 11 men made a complete recovery, while 4 out of 8 women failed to make a complete recovery (the great majority being treated by prednisolone at 20 mg per day). I wonder if this clinical impression (i.e., that women fare worse than men) was borne out by Dr. Taverner's patients.

Finally, there is still doubt in some circles whether steroids in any form influence the outcome of this condition, since Dr. Taverner and colleagues' trial of 1966[1] was stopped prematurely and in the final results the differences did not reach statistical significance, the early sequential analysis having by chance exaggerated the effectiveness of the ACTH treatment. Conclusions were in fact based on "expected values" rather than direct controls. In the present trial, therefore, it might have clarified the case for steroids had the potential controls—i.e., the patients excluded because of late arrival, etc. —been followed up as well as the two treated groups.—I am, etc.,

W. T. BERRILL

Southampton General Hospital,
Southampton

1 Taverner, D., Fearnley, M. E., Kemble, F., Miles, D. W., and Peiris, O. A., *British Medical Journal*, 1966, 1, 391.

Vasectomy

SIR,—I would like to support the view of Mr. N. A. Regan (23 October, p. 233), who criticizes the article by Mr. David M. Wallace and Mr. Peter Riddle (9 October, p. 100) on the grounds that they are attempting to make a simple operation difficult. As Mr. Regan says, there is no difficulty in performing the operation under local anaesthesia and in achieving satisfactory separation of the cut ends of the vas. We should aim to make the operation of vasectomy as simple and atraumatic as possible. I would like to pass on a few simple technical points that I feel help towards this goal.

A thorough shave is unnecessary. Only a small area of skin at the base of the scrotum need be shaved.

A small tranquillizing dose of diazepam (usually 10 mg intravenously) allows the patient to enjoy the operation and makes the surgeon's task easier.

The vas is palpated through the scrotal skin and is stretched taut across the surgeon's middle finger held behind the scrotum by the thumb and index finger in front of the scrotum. The vas can then usually be seen beneath the stretched scrotal skin. 4 ml of 1% lignocaine is then infiltrated beneath a 2-cm-diameter area of skin and around the underlying vas cranially.

A 1-cm-long incision is made with a diathermy point directly over the vas, which is still held tightly stretched over the middle finger.

The incision is taken right down on to the wall of the vas, which can then be lifted out with tissue forceps a sa loop without causing discomfort. A small section of the vas may then be removed if histological verification of the anatomy is required. The ends of the vas are ligated. One end is turned back as a U and the other left buried in a different layer of the scrotal tissues.

A continuous Dexon suture taking the skin and the deep layers of the scrotum enables haemostasis to be secured and the skin to be closed with only two or three loops of the stitch. If this technique is followed a haematoma is avoided.

If it is ever necessary to reconstruct the vas there is little difficulty in finding the ends, removing the ligated portion, undoing the U, and performing an anastomosis without tension. I have recently had occasion to perform a reanastomosis of a vasoligation performed in this manner. Apart from the technical tedium of an anastomosis using magnifying spectacles the reoperation was simple to perform. A normal sperm count was confirmed at one month after the operation. Both the vasoligation and the reconstruction were performed on an outpatient basis, though the reconstruction was performed under general anaesthesia.

I am prompted to write this letter as a plea for simplicity. There is always a danger that specialists will tempt to make operations so complex that they can be performed only by specialists.—I am, etc.,

J. ALEXANDER WILLIAMS

The General Hospital,
Birmingham

Starch Granulomatosis of the Peritoneum

SIR,—Following the study of three patients admitted under the care of one team in this hospital within the last nine months, I am interested in the article and correspondence concerning granulomatous reaction in the peritoneum.

The clinical features of our cases are remarkably similar to those of Mr. J. F. Colin and Mr. C. Wastell, (2 October, p. 47). The first, a man of 34 was diagnosed as suffering from a duodenal ulcer whose presence was not confirmed at laparotomy in November 1970. Further laparotomy was indicated during the third re-admisson for recurrence of severe pain and continuing ill-health, with marked rebound tenderness in the epigastrium. This was performed nine weeks after the first operation and revealed a densely indurated wound and great difficulty was found in defining the peritoneal cavity. The omentum was grossly thickened and adherent and ultimately a collection of clear fluid was drained from the upper abdomen. Other than biopsies and drainage no operative procedure was performed. The postoperative course was marred by a small pulmonary embolus, but otherwise recovery was complete.

The second, a 53-year-old man, was admitted for cholecystectomy which was performed routinely in May 1971. He suffered a wound dehiscence on the 10th postoperative day, this being resutured using floss nylon sutures. He was discharged 14 days later but required readmission on 16 June suffering from recurrent abdominal pain, with marked rebound tenderness in the left iliac fossa. Laparotomy was performed six weeks after the initial operation revealing three litres of clear fluid, with massive induration of the greater omentum, but no other lesion referrable to the previous operation. His postoperative improvement was slow but steady.

The third, a woman of 38, was again an otherwise routine cholecystectomy for stones, but on whom sterilization by salpingectomy was also performed. She was discharged apparently well after 12 days, but required readmission on the 26th postoperative day with abdominal pain and rebound tenderness maximal in the left hypochondrium. Her illness rapidly worsened and three days later she required laparotomy for signs of large bowel obstruction. As in the other cases dense adhesions particularly of the greater omentum were found and a blood-stained collection of peritoneal fluid was obtained. The adhesions had led to obstruction of the sigmoid colon.

The features common to the above cases were of continuing abdominal pain, marked rebound tenderness and normal haematological and biochemical readings apart from the E.S.R., which was significantly raised in all cases (60, 45, and 58 mm/in 1 hr respectively). The association with a recent surgical operation was undeniable and the operative findings were remarkably similar. The fluid obtained from each patient was sterile and microscopy of the omentum revealed a granulomatous reaction with giant cells, but no foreign body particle could be identified, even when using polarized light and after review of the specimens in the light of the recent publications.

It is of interest that the above three cases and the two reported by Mr. Colin and Mr. Wastell did not exhibit the typical starch granules noted by the other authors[1-3] and thus it is difficult to incriminate glove powder as the causative agent. The manufacturers of our gloves have assured me that no new processes have been introduced into their products, and they believe that the materials in present use are totally inert.

As a result of this I feel that when the presence of starch granulomata cannot be demonstrated histologically, the condition would be better known as a non-specific (postoperative) granulomatous peritonitis. The measurement of the E.S.R. may be of some help in its preoperative diagnosis.—I am, etc.,

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1 Neely, J., and Davies, J. D., *British Medical Journal*, 1971, 3, 625.
2 Ellison-Nash, D. F., *British Medical Journal*, 1971, 3, 183.
3 Michaels, L., *British Medical Journal*, 1971, 3, 369.

Keeping Medical Records

SIR,—I must congratulate Sir Herbert Seddon (9 October, p. 103) on his splendid article dealing with medical records. It was gratifying to find a most eminent member of the medical profession who is not only aware of the department and its functions, but conscious of the numerous problems associated with running it.

I should like to enlarge on the subject of staff by a mention of the Cinderella of them all—the backroom filing clerk. The receptionist in the outpatients department has a bit of glamour in her position (some patients have been known to give the odd box of chocolates); the medical secretary tends to shine in the reflected glory of her consultant(s); but who acknowledges, or indeed ever sees, that queen of the backroom girls—the filing clerk who with meticulous and dedicated care ensures that Mrs. Jones's path report is filed in the case notes of the *right* Mrs. Jones and who toils all day to pull the records for today's outpatient clinics; and tomorrow files them all away again?

In London it is extremely difficult to recruit suitable staff. It is all very well to talk piously about job satisfaction—a very necessary ingredient, but so also is a decent salary. Then there is the question of working environment. How often one finds the