potential at the wrist of at least 8.5 μ V with a latency of less than 2.8 ms. Tinel's sign, sought by tapping the volar aspect of the wrist with a finger, was regarded as positive when tingling or mild electric shock sensations were felt in the median nerve territory in the hand. The data (see table) were arranged in a 2 $\times$ 2 contingency table and a χ^2 test performed.

Presence of Tinel's sign in hands with and without CTS

	With CTS	Without CTS
No of hands	51	52
No of subjects	37	38
Age range (years)	36-84	30-84
Mean age (years)	55	53
% Women	81	79
Tinel's sign present	23 (45%)*	15 (29%)*

* $\chi^2 = 2.26$; $P = 0.10$.

Comment

The popularity of Tinel's sign as applied to CTS is probably attributable to Phalen,⁴ who found it present in 73% of 621 hands with alleged CTS. None of his patients, however, had electrodiagnostic confirmation. Only 40% of the hands underwent decompression, the others improving with conservative measures. Thus confirmation by exploration was impossible in the majority. Furthermore, it is unusual for 60% of hands with CTS to recover without decompression. There is, therefore, some uncertainty about how many of Phalen's patients had CTS. So far as we know neither Phalen nor anyone else has systematically examined a series of normal hands for the presence of Tinel's sign, although Hamlin and Lehman⁵ state simply that it may occur in the absence of CTS. Even trivial pressure on a normal ulnar nerve at the elbow will often produce tingling in the ulnar innervated part of the hand. The same occurs with normal median nerves at the wrist, although less commonly, presumably because of the partial protection afforded by the thick transverse carpal ligament. Our findings show that compression of the median nerve in the carpal tunnel does not add appreciably to its sensitivity. We therefore conclude that this adaptation of Tinel's sign is of no diagnostic value.

Requests for reprints should be addressed to: Professor J D Stewart, Montreal General Hospital, Division of Neurology, 1650 Cedar Avenue, Montreal, Quebec H3G 1A4, Canada.

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Department of Neurology and Neurosurgery, McGill University, and Montreal Neurological Institute, Montreal, Quebec H3A 2B4, Canada

J D STEWART, MRCP, FRCP(C), assistant professor
A EISEN, MD, FRCP(C), associate professor

Timing of female sterilisation

Female sterilisation as a method of contraception is increasing. It is now one of the most common gynaecological operations in the West Midlands. The decision to sterilise seems often to be reached in haste with inadequate counselling and at a time when the woman can least make a well-balanced judgment, such as immediately before or after delivery. We investigated whether the timing of sterilisation affected its outcome and its relationship to satisfaction with the operation.

Patients, methods, and results

Two groups of women were followed up for two to seven years after sterilisation. Eighty had been sterilised at caesarean section and 105 between

the second and fifth days postpartum. We visited them at their homes. Full histories were taken, with particular emphasis on the reasons for sterilisation, who had suggested the operation, the outcome, and subsequent satisfaction. The patients were divided into three groups: those who were entirely satisfied with the operation, those who deeply regretted their original decision, and those who had significant regrets, which they related to sterilisation, but who basically stood by their decision. The last were placed in a "relatively dissatisfied" group. We used the same method when examining 151 interval sterilisations, and the patients in that study were used for comparison.¹

The average age at sterilisation was 28.6 years, no woman had fewer than two children, and all social classes were represented. None of these factors was significantly associated with dissatisfaction. Most sterilisations were done for socioeconomic reasons, although one-third of the caesarean section group were recommended the operation solely because they had had two or more previous sections. The level of satisfaction with the operation was compared with that among the interval group (table). Rates of dissatisfaction in the postpartum and caesarean section groups were 8.7% and 11.4% respectively.

Results compared with those after interval sterilisation

	Caesarean section	Postpartum	Interval	Total
Satisfied	62	77	146	285
Relatively dissatisfied	11	16	0	27
Dissatisfied	7	12	5	24
Total	80	105	151	336

$\chi^2 = 34.14$. $P = 0.001$.

These rose to 26.7% and 22.5% if the "relatively dissatisfied" were included. The level of dissatisfaction in the interval group was 3.3% and there were no "relatively dissatisfied." One-third of all operations were recommended by doctors. Of the "dissatisfied," all were suggested by a doctor in the caesarean section group, and 75% in the postpartum group. Histories of manifest psychiatric illness did not adversely affect outcome. Nevertheless, the six with severe personality disorders were represented exclusively in the "relatively dissatisfied" and "dissatisfied" groups.

Comment

The greater the interval from any obstetric event the better were the results of sterilisation. Only 1% of women regretted sterilisation when performed by laparoscopy at a varying interval from the last confinement.² This low incidence is comparable with our own results after interval sterilisation. The increased incidence of dissatisfied patients which we found in the caesarean section and postpartum groups complements the findings of Winston³ in 103 patients seeking reversal of sterilisation, two-thirds of whom had been sterilised immediately after pregnancy. There was also a high incidence of relatively dissatisfied patients in postpartum and caesarean section groups, and, although these patients eventually felt they had made the right decision, much distress could have been avoided by performing the operation at a later date. In all cases interval sterilisation could have been recommended.

Previous psychiatric illness should be no contraindication to sterilisation, but women with severe personality disorders are likely to be dissatisfied. This probability has to be weighed against the often clear social advantages of recommending sterilisation. An increasing number of younger women are being sterilised, but there is no evidence of a disproportionate number among them who regret the operation. More regret is expressed by those to whom doctors recommend sterilisation, and that raises a serious objection to this common practice. The need for both partners to be counselled before performing sterilisation cannot be too strongly emphasised.

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Birmingham Maternity Hospital, Birmingham B15 2TG

J MICHAEL EMENS, MB, MRCP, senior registrar

All Saints' Hospital, Birmingham B18 5SD

J EDWARD OLIVE, MB, MRCPsych, senior registrar