estimated proportion of positive smears (smears classified as severe dysplasia/carcinoma in situ or carcinoma in situ/query invasive) from the 25-35 year age group has more than doubled between 1973 and 1980, and during this same time the death rate from cervical cancer has increased only in these younger women.[1]

The numbers of deaths are small, but the death of a young woman from a preventable disease is a tragedy. Encouragement should continue to be given to cervical screening programmes for premenopausal women, as education on the value and simplicity of cervical screening to this group should encourage them to continue attending for cervical smears postmenopausally. For screening to be effective the age group at which maximum screening occurs must precede the age group with the highest incidence of cervical carcinoma. Surely, screening of premenopausal women should also be encouraged on these grounds.

Dr Husain quotes Dr Macgregor's Aberdeen experience that only 10% of women dying of cervical cancer have ever had a cervical smear, as reflecting the tragedy caused by the intensive screening of the younger age groups.[2] Surely, this work simply emphasises how effective cervical screening is in the early detection and treatment of the disease in the remaining population. Other studies are more worrying; notably that between 28% and 80% of women with cervical cancer have had cervical smears, and, between 58% and 100% of those women who have been screened for cervical cancer and subsequently developed the disease had a normal cervical smear report within five years of diagnosis.[3-5] In some of these cases errors of sampling or reading the cervical smears must have existed. Nevertheless, in view of the increase in cervical neoplasia in young women and the evidence that the natural history of the disease may be less than five years in a few women, should we not be concentrating on a programme of three yearly cervical smears for asymptomatic premenopausal women and introducing measures to cut down unnecessary repeat smears?

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[1] Roberts A. Cervical cytology in England and Wales, 1965-80. *Health Trends* 1982;**14**:41-3.
[2] Macgregor JE. *Taking uterine cervical smears*. Aberdeen: University of Aberdeen Press, 1980.
[3] Walker EM, Hare MJ, Cooper P. A retrospective review of cervical cytology in women developing invasive squamous cell carcinoma. *Br J Obstet Gynaecol* 1983;**90**:1087-91.
[4] Rylander E. Cervical cancer in women belonging to a cytologically screened population. *Acta Obstet Gynecol Scand* 1976;**55**:361-6.
[5] Bamford PN, Beilby JOW, Steel JS, Viles R. The natural history of cervical intra-epithelial neoplasia as determined by cytology and colposcopic biopsy. *Acta Cytologica* 1983;**27**:482-4.

The rattled CSM should think again

SIR,—Another antirheumatic drug fenclofenac (Flenac) has been refused a continuation of its licence by the Committee on Safety of Medicines (CSM) and joins a growing list of proscribed and limited drugs—benoxaprofen, indoprofen, osmotically released indomethacin, oxyphenbutazone, feprazone, and the severely curtailed phenylbutazone.

Fenclofenac was not a distinguished drug; yet it had its advocates and at one time was considered as a possible second line antirheumatic agent. In this respect it is similar to another of its banned contemporaries—benoxaprofen. Like all the non-steroidal anti-inflammatory drugs it suited some patients well while in others it produced the side effects that occur with all these drugs—gastrointestinal upset, rashes, fluid retention, and haematological disorders.

This blanket ban on fenclofenac and the other drugs must be of great concern to rheumatologists and patients alike. While there may be a case to be made for restricting the use of certain drugs to specialised clinics—for instance, phenylbutazone—the total banning of drugs and indeed edicts on the precise indications for their usage indicates how much the CSM has been rattled by the media treatment of recent drug controversies.

If it pursues this line then a case could be made for the withdrawal of many if not all of the current non-steroidal anti-inflammatory drugs—some of which owe more to acute marketing techniques rather than superior efficacy. Indeed, logically extended a case could be made for the removal of gold and penicillamine from routine use in treating rheumatoid arthritis.

In denying the use of these drugs to rheumatologists, the CSM is telling us that our training and experience is inadequate to use the drugs of our specialty. In denying the use to patients the CSM is going to cause unnecessary suffering, particularly to those patients already established on fenclofenac; many will have to undergo the lottery of finding another suitable agent. Only the patients suffer, and the CSM should think again.

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Late failure of vasectomy

SIR,—The warning by Mr Tim Philp and others (14 July, p 77) of late failure of vasectomy is important. I know of three similar cases in Bristol where pregnancies have resulted under identical circumstances. We have since modified our preoperative counselling document to include this eventually as a remote possibility. The medicolegal implications are such that I believe this should become the standard practice in all vasectomy clinics.

Regarding the technique of vasectomy, Mr Philp and others cite the paper by Schmidt—he has reported the largest single series of vasectomies without recanalisation.[1] The success of his technique is probably not due to sealing the ends of the divided vasa with diathermy but the interposition of viable tissue between the ends so that they lie in separate planes. The diathermy current can be conducted down a considerable length of the vas and render attempts at reversal unsuccessful. Bearing in mind the ever increasing incidence of marital breakdown and consequently the numbers requesting reversal of vasectomy this possibility should be taken into consideration when performing the vasectomy.

The operation should be undertaken as high as possible in the scrotum to avoid the lower convoluted portion of the vas. Like Mr Philp and others I no longer excise a segment and prefer to seal the ends with ligaclips, one on the proximal end and two on the lower end. In over 900 operations that I have performed only one patient has failed to clear his ejaculate of sperm.

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[1] Schmidt SS. Prevention of failure in vasectomy. *J Urol* 1973;**109**:296-7.

SIR,—It is unfortunate that Mr Tim Philp and others imply that the "rare possibility of later failure of vasectomy" is a complication of the operation regardless of the technique used. This is incorrect, for the data from their series and references apply only to the techniques used, which rarely includes the theoretically important step of interposing fascia between the cut (and surgically obstructed) ends of the vas.

Unless several centimetres of vas are excised the fascial planes and the constant natural movements of the scrotal contents will tend to draw the treated ends of the vas together and into alignment, thereby facilitating recanalisation if there is any leakage from failure of the ligature or diathermy occlusion. Fascial interposition should prevent both the approximation of the cut ends and their alignment.

As the incidence of late recanalisation is estimated as being rarer than 1:2300 an individual surgeon using fascial interposition is unlikely to be able to produce objective evidence of its superiority (or otherwise). But unless such a technique is sought and is shown to be free from the complication of late recanalisation doctors will be obliged to advise all patients that there is a definite risk of late failure. This policy can hardly be in the patient's best interest, and it may inhibit the search for more reliable techniques.

Maybe if all surgeons who invariably include fascial interposition in their vasectomy techniques were to pool their data a clear answer to this aspect of the problem would be already available. But if this technique is also shown to fail, we surely ought to be considering a more extensive procedure such as excising several centimetres of vas. This must be better than to carry out a potentially useless operation and expect the patient to accept the responsibility for avoiding the risk by behaving as if the operation had never been done.

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SIR,—In their report on the late failure of vasectomy, Mr Tim Philp and others support our recently published observations and conclusions.[1] Their recurrence rate is 0·02%, an extremely low figure. Although they suggested, on other data, the possibility of a figure as high as 1%, a more realistic figure of 0·05% was preferred.

In our clinical service over nine years several surgeons performed 4934 vasectomies using a standard vas excision/ligation technique. Excluding initial failures, four patients (0·08%) developed appreciable delayed recanalisation; there was no apparent reason. But 490 patients (10%) failed to complete their seminal examination, suggesting the

possibility of many delayed failures. No mention was made in Mr Philp and others' paper of patients failing to complete the investigations; were there any? Another factor which must be considered is the reduced or absent fertility of the spouses of the older patients. We believe, as Mr Philp and others have implied, that the delayed recanalisation may be more common than at present recorded.

Delayed spontaneous recanalisation has been the subject of litigation. As a consequence of this case and our own observations our counselling and consent form emphasise the possibility of a late failure of the operation because we do not believe that a surgeon should be held responsible for events beyond his control. This differs slightly from the practical action proposed by Mr Philp and others, with which we fully agree.

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[1] Sherlock DJ, Holl-Allen RTJ. Delayed spontaneous recanalisation of the vas deferens. *Br J Surg* 1984;**71**:532-3.

Management of obstructed balloon catheters

SIR,—Mr Gavin G P Browning and others (14 July, p 89) describe a useful but little known method of dealing with obstructed balloon catheters: a wire ureteric catheter stylet is passed along the balloon inflation channel to dislodge an obstruction or to puncture the balloon. They state that this is a safe and simple method without complications. My experience of this method is less than their 16 cases, but in two patients the wire stylet has not negotiated the inflation channel and has punctured the catheter wall.

With the first patient a latex Foley catheter had been in place for some time, and the catheter balloon could not be deflated. While the stylet was being passed the patient complained of severe pain. The procedure was abandoned, and the catheter was removed after suprapubic needle puncture of the balloon under general anaesthetic. The catheter had been punctured by the stylet in its middle portion.

The second patient's catheter had been in place for only a few days and was successfully removed using a wire stylet. The procedure was difficult, and the wire encountered an obstruction which could not be negotiated. The wire was withdrawn and the attempt abandoned. The catheter fell, out, however, when the balloon deflated spontaneously because of a hole in the side of the catheter. Again the stylet had punctured the wall of the catheter some distance from the balloon. There were no immediate complications in either patient.

This technique is not without hazard, and I think it should not be used by the inexperienced, particularly if the catheter is in poor condition.

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SIR,—Mr Gavin G P Browning and others correctly point out that transcatheter puncture of the catheter balloon with a ureteric catheter wire stylet is the simplest and most effective method of managing an obstructed balloon catheter. There are, however, occasions when this and other commonly employed techniques may fail. In three old men I have successfully removed the catheter by puncturing the balloon through the urethra using an optical urethrotome with the patient under a light anaesthetic. A metal bougie is first passed alongside the catheter to determine whether or not the urethra is capacious enough to accommodate the instrument, traction applied to the catheter, and the balloon successfully punctured with the knife blade attachment under direct vision.

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SIR,—In our experience in men with blocked urinary catheters the technique described by Mr Gavin G P Browning and others is often unsuccessful because the wire stylet cannot be negotiated around the curve where the catheter passes through the membranous urethra. We note that only seven of their patients were men, and there is no indication of how many had urinary catheters.

When transcatheter insertion fails the balloon can be punctured easily using a fine spinal needle. This is introduced transcutaneously one inch above the symphysis pubis after a small subcutaneous injection of local anaesthetic. A finger in the rectum allows the balloon to be felt, and the needle can then be advanced without radiological control towards the finger thus puncturing the balloon.

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SIR,—Mr Gavin G P Browning and others have described a well established technique of deflating obstructed balloon catheters, and doctors faced with this consternating problem may like to know of another recent paper.[1] Moskovich was not so successful as Mr Browning and others: his stylet failed to deflate the balloons in four successive men. He recommends in these circumstances balloon puncture by a percutaneous needle introduced suprapubically. Based on cadaver studies, he recommends angles of entry for men and women. He also suggests that a plain radiograph of the pelvis may be helpful in establishing the position of the balloon.

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[1] Moskovich R. Suprapubic puncture for non-deflating urethral balloon catheters. *J R Coll Surg Edinb* 1984;**29**:181-3.

SIR,—We have removed blocked urethral balloon catheters successfully on several occasions using the technique described by Mr Gavin G P Browning and others. But a recent failure forced us to adopt another strategy. The patient, a man with disseminated sclerosis, was referred because his catheter failed to deflate. All the common methods had already been tried so an attempt was made to deflate the balloon by "transcatheter puncture." Although several varieties of stylet were used, this method also failed.

As it was not possible to arrange an ultrasonic scan to carry out percutaneous puncture the patient was taken to theatre. Under a general anaesthetic, the patient's catheter was divided and pushed into the bladder using an urethrotome. It was then quite easy to "stab" the balloon under direct vision with the urethrotome knife. The catheter was then removed using grasping forceps. Several fragments of calcified encrustations which had presumably prevented the balloon from deflating were washed out from the bladder through the urethrotome sheath.

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SIR,—The method described by Mr Gavin GP Browning and others is obviously effective, but a ureteric catheter stylet may not always be readily available. I have successfully used a simpler technique for obstructed urethral catheters in women. A green Argyle Medicut intravenous cannula without the inner needle is lubricated and passed up the urethra alongside the catheter until it abuts on to the balloon. The needle is then simply inserted through the cannula and the balloon punctured. The needle is withdrawn followed by the cannula and catheter.

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No ladies or girls please—just women

SIR,—Although only a fledgling gynaecologist I was taken aback by Jean Robinson's letter telling us not to use the term lady (30 June, p 2003). My impression is that lady is the correct and polite word for referring to an adult female. I refuse to ask "How many women are there to see today?" or to say "This way please, women." This has nothing to do with chauvinism or debasing of the "adult woman," for whom I have the greatest respect. This is the English language and I shall continue to use it in the generally accepted manner.

I am pleased to say that this view is endorsed by the female members of my department, who consider both themselves and their patients as ladies.

NIGEL F PERKS
(gentleman)
Endorsed by:
ANNE FOY
SHEILA MCPHAIL
AMANDA J SMITH
LORNA TAYLOR
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(all ladies)

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*** We have received many other letters that support Dr Perks and his ladies.—ED, *BMJ*.