antitrypsin level.³ These three conditions have well described lung involvement and the common occurrence of antitrypsin deficiency may have important implications. This problem is now under investigation in this laboratory.—We are, etc.,

O. FITZGERALD.
K. F. McGEENEY.
B. GILHOOLY.

Department of Medicine and Therapeutics,
University College,
Dublin 4.

REFERENCES

- 1 Dietz, A. A., Hodges, L. K., Rubinstein, H. M., and Briney, R. R., *Clinical Chemistry*, 1967, 13, 242.
- 2 Evans, H. E., Levi, M., and Mandl, I., *American Review of Respiratory Disease*, 1970, 101, 359.
- 3 Eriksson, S., *Acta Medica Scandinavica*, 1965, 177, Suppl. No. 432, p. 1.

Male Sterilization

SIR.—Dr. Pauline Jackson and others (31 October, p. 295) require two semen analyses to show azoospermia at an interval of one month. In order to avoid the patient having to use contraceptives longer than necessary, it is perfectly reasonable to ask for two specimens at an interval of 7-14 days—that is, long enough to allow the seminal vesicles to fill up again.

After vasectomy, I ask that at least two months shall have elapsed since the operation, and that he shall have ejaculated at least 15 times. After that, he should not ejaculate for at least three days, in order to produce the biggest possible specimen straight into a 50-ml. container which has a wide mouth, and is provided by the laboratory. If that is clear, a second specimen is requested 7-14 days later. If one of those is not clear, he is sent another container for use not before 10 days have elapsed and after he has had at least another five ejaculations. When two consecutive specimens have been found free of sperm, contraceptive precautions can be abandoned.

The object of asking for two specimens is to make assurance doubly sure, and to satisfy a court of law in the event of litigation.¹ It is not to check whether recanalization has taken place. Hanley² has shown that this takes considerably longer.

As a matter of terminology, aspermia, which means complete absence of sperm, seems a more accurate term than azoospermia, which means absence of living sperm and implies that non-motile sperm can be present.—I am, etc.,

H. C. M. WALTON.

Beck Laboratory,
Swansea Hospital.

REFERENCES

- 1 Constable, H., *Lancet*, 1968, 2, 1246.
- 2 Hanley, H. G., *Lancet*, 1968, 2, 207.

Phentolamine in Heart Block

SIR.—I am prompted by the recent remarks in your columns (31 October, p. 307, and 28 November, p. 558) about the drug treatment of heart block to comment that, in my experience, a short course of a glucocorticoid (such as prednisolone, starting at 40 mg. per day) will nearly always change A/V block (complete or incomplete) and/or bundle

branch block (left or right, complete or incomplete) back to sinus rhythm when the conduction fault follows a recent myocardial infarction.

Presumably the action of the drug is to reduce oedema, as it will do in uncomplicated cerebral oedema following concussion.—I am, etc.,

J. H. MITCHELL.

Caithness Central Hospital,
Wick, Caithness.

Colistin Sulphomethate Sodium and Renal Function

SIR.—We refer to the paper by Mr. D. J. E. Price and Dr. D. I. Graham (28 November, p. 525) where the summary appeared to misrepresent the actual findings. We wish to point out that although the authors considered renal failure to have contributed to the final cause of death in some cases, which it should be noted were severely ill patients with refractory infections when treatment was started, in only one case was renal failure the actual cause of death in this difficult group of cases receiving exceptionally high dosages of colistin.

Furthermore, no mention was made in the summary of the reversible nature of the biochemical changes which occurred following colistin, as indicated by the findings in all patients who survived, including those considered to have developed acute tubular necrosis and as suggested by the available biochemical data in those patients who died. In our opinion the summary does therefore not accurately portray the content of this paper.—We are, etc.,

EUSTACE SPROSTON.
M. P. MCCONNELL.

Medical Department,
Pharmax Ltd.,
Crayford, Kent.

** We have shown the above letter to Mr. D. J. E. Price and Dr. D. I. Graham who reply: "We would like to thank Dr. E. Sproston and Mr. M. P. McConnell for drawing to our attention that our summary was incomplete. As they have rightly pointed out, the high dosages of colistin used produced completely reversible nephrotoxicity in the surviving patients even though the biochemical data suggested that it had produced acute renal failure in some and acute tubular necrosis in others. In those patients who died there was an indication that the nephrotoxicity was also reversible, and again we would like to stress that renal failure may have contributed to the fatal outcome in some of our patients but in the majority they died from the primary neurological disease."—ED., *B.M.J.*

Accident and Emergency Services

SIR.—I have followed the recent correspondence on the accident and emergency services with interest, and from the viewpoint of a career appointment in this branch of hospital medicine would like to make a few observations.

I am afraid that I cannot confirm that three quarters of the patients attending the casualty department of this hospital could

be regarded as general practitioner cases. Letters from Mr. F. C. Durbin and Dr. R. W. Stephenson (28 November, p. 557) prompted me to make a quick check by selecting a week at random and analysing all the attendances. Total attendances were 443, of which 226 were new cases. Of these latter 12 could have been dealt with by a general practitioner by examination and prescription only and an additional 42 could possibly have been dealt with if every general practitioner had 24-hour facilities for minor suturing, dressing small burns, strapping minor sprains, incising paronychia, etc. Even this latter maximum figure only represents 7 to 8 patients a day. Of patients referred to other faculties for admission or outpatients follow-up 36 were orthopaedic and 28 for other departments.

To subdivide the work into "orthopaedic" or "general practitioner," as suggested by Dr. Stephenson, is an oversimplification, as it does not easily accommodate such cases as the ruptured spleen or spontaneous pneumothorax. Many emergency ambulance cases will involve other specialties and will require assessing and possibly immediate medical treatment or even resuscitation. Someone will be required to receive and assess such cases, including those of multiple trauma, at the same time rendering the condition non-urgent before referring to the relevant specialty. This person will also be able to deal with the less severe trauma and illnesses that can have a high morbidity if not treated vigorously.

To effectively liaise with senior members of other departments, with general practitioners, ambulance, and other outside services it is surely a considerable advantage to have a permanent member of staff in the department, and with junior medical and ancillary staff this person can then run the department and represent its interests first hand. That this requires experience and training is recognized by Mr. Durbin's suggested "special crash courses of training." So if the person will end up as a "specialist" why not a "consultant"?—I am, etc.,

R. SNOOK.

St. Martin's Hospital,
Bath.

Survival Rates with Dialysis

SIR.—I read with interest the article by Dr. J. F. Moorhead and colleagues on survival rates of dialysis and transplantation (10 October, p. 83). While sympathising with the difficulties that the authors must have had in compiling data going back seven years when none of them was actively involved in the early years of this work, I nevertheless feel that it is necessary to add three apparently unreported early deaths in the hospital series.

In September 1963 a male patient aged 20 died after five months of treatment from inhalation of blood following epistaxis associated with heparin. In December 1963 a male patient¹ aged 35 died after 10 months from a massive right heart embolus associated with the use of indwelling femoral catheters, and in March 1966 a male patient died aged 45 after three weeks' treatment from a cardiac tamponade. I could not find any mention of these deaths in their mortality analysis. Furthermore,

they have not made clear that two out of three of the seven-year survivors were in fact treated for 9 months and 22 months respectively by haemodialysis in other units before referral to the Royal Free, and contemporaries of these patients at the other units concerned have died in the interim period.

While in no way wishing to detract from the extremely successful results they report, it is clear that a higher mortality rate exists with this treatment when methods are being developed and there is staff inexperience.—I am, etc.,

STANLEY SHALDON.

National Kidney Centre,
London N.3.

REFERENCE

- ¹ Shaldon, S., Baillod, R., Comty, C., Oakley, J., and Sevit, L. *Proceedings of the European Dialysis and Transplant Association*, 1964, 1, 233.

Depression and Oral Contraception

SIR,—Dr. J. T. Hart (7 November, p. 367) and Dr. K. L. Oldershaw (21 November, p. 496) comment on the personality characteristics of Dr. Brenda N. Herzberg's control group of women attending F.P.A. clinics and not taking oral contraceptive pills (17 October, p. 142).

From my experience of working in an F.P.A. clinic I consider that Dr. Oldershaw's division of women into pill-takers and non-pill-takers according to whether or not they want 100% reliability does not hold good in the simple fashion he suggests. This may be because we are seeing different samples of women. Many fertile women still attend F.P.A. clinics having been using diaphragms successfully since before oral contraceptives became available.

Representation of M.R.C. Staff

SIR,—Your leading article (5 December, p. 574) does less than justice to the Commission on Industrial Relations. You say of the commission's inquiry¹ into the Medical Research Council that it "seems to have been reduced to the level of a numbers game. . . ." But in fact numbers were not the main criterion for recognition; only one component in a framework of argument. The C.I.R. was required to recommend a system of "industrial" relations for the M.R.C. It first investigated *how* staff should be represented, and, for reasons which I have not space to expound, recommended that there should be a single association for all non-clinical scientific and technical staff. The whole of the recommendations rests upon this, in my opinion, wise decision. The commission then had to recommend by whom the staff should be represented. The B.M.A. and the Association of University Teachers would not take technicians, and the Institution of Professional Civil Servants had, contrary to your leading article, evinced no interest in the M.R.C. Of the two remaining associations, the Association of the Medical Research Council Scientific and Technical Staff was excluded primarily because of doubts about its future viability as a small scattered organization largely dependent on voluntary officers, and also because it appeared to have less support in a poll whose confidence limits were considerably more strin-

My impressions confirm Dr. Hart's that they are of stable temperament, many in their 40's. However, if women in this age group are more prone to depressive illnesses than are younger women, the discrepancy between incidence of depression in oral contraceptive users and non-users may be all the more significant.

Now that there is a wider choice of contraceptive method, considerations other than reliability still operate. Some of these are convenience, experience of friends and relations, fear of side effects of oral contraceptives, and actual experience of these—both trivial and serious.

From examination of the clinical notes of women coming to my clinic for the first time it appears that we are still successfully providing mechanical methods of contraception for women with a wide scatter of age, parity, and personality types.—I am, etc.,

PATRICIA JORDAN.

Pontefract, Yorks.

Christmas Gifts Fund Appeal

SIR,—I should like to remind your readers who have not yet responded to the President's appeal that it is our custom to distribute the gifts in good time for Christmas.

I hope all who can will send their contributions marked "Christmas Gifts" to the Royal Medical Benevolent Fund, at 24 King's Road, Wimbledon, London, S.W.19 as soon as possible.—I am, etc.,

G. H. BATEMAN,
Honorary Treasurer,
Royal Medical Benevolent Fund.

London S.W.19.

paragraph of your leading article. Anyone who has read it might suppose that Park Crescent is about to be besieged by hordes of bloodthirsty technicians. You will have ample opportunity to correct this misapprehension since representatives of the B.M.A. and A.S.T.M.S. will be sitting around the same table with the M.R.C. on the negotiating body. I hope that we shall be able to work together in amicable cooperation.—I am, etc.,

ROGER WEST.

London, N.W.4.

REFERENCES

- ¹ Commission on Industrial Relations, *Report No. 12, Medical Research Council*, Cmd. 4531. London, H.M.S.O., 1970.

Prescription Charges

SIR,—I should like to support Dr. D. W. Gabriel (21 November, p. 498) on the injustice of prescription charges. The "season ticket" scheme by which any patient may buy exemption from charges for six or twelve months on form E.C.95 deserves more publicity, but even this scheme gives insufficient help to some patients with severe disabling illnesses requiring much treatment.

The logic of the list of specified conditions exempting patients from prescription charges is hard to discern. For instance, patients with external fistulae requiring dressings are exempted, but patients with internal fistulae from Crohn's disease are not exempted although they may need more treatment and although the resulting disability may be greater. Another example of apparent inconsistency is the omission of a number of conditions, such as pernicious anaemia and some other malabsorption states requiring "specific substitution therapy," which is the reason given for the inclusion of some endocrine disorders.

Many more examples of chronic disabling conditions could be given. As Dr. Gabriel mentions, many patients with chronic heart or chest disease need a great deal of treatment and are among those least able to pay the charges. It seems particularly strange that malignant disease is not included and that patients with leukaemia should have to pay for their cytotoxic drugs.—I am, etc.,

JAMES STEWART.

West Middlesex Hospital,
Isleworth, Middx.

B.M.A. Deputizing Services

SIR,—The document on B.M.A. Deputizing Services just sent to all subscribers and deputies by Dr. I. M. Jones on behalf of the Central Advisory Committee has been read by the Bristol deputies with astonishment and disbelief.

The rates described for deputies, to be introduced "concurrent with the introduction of a national scale of fees for subscribers" are parsimonious. The further statement that "a minor modification of these arrangements is already in operation