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 1966¹ 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.,

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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 tranquilizing 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.,

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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-admission 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 re-admission 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 referable 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 re-admission 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 ad-

hesions 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 authors¹⁻³ 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