decision to reduce the birth rate, irrespective of the consequences such measures may have on the life of an individual. When advising procedures which "permanently" deny procreation, it is important that the physician be not carried away with his own enthusiasm for the operation and by his public-spiritedness. The paramount concern, as always, should be the future happiness and emotional stability of his patient.—We are, etc.,

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R. GAIND

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¹ Sawhney, N., Nathawat, S. S., and Sethi, B. B., *Indian Journal of Psychiatry*, 1970, 12, 155.

² Wig, N. N., Singh, S., Sahas, G., and Isaac, P., *Indian Journal of Psychiatry*, 1970, 12, 169

Antibody Response to A/England/42/72 Influenza Vaccine

SIR,—Dr. Marguerite Pereira and others (23 December 1972, p. 701) reported that a commercial influenza vaccine containing A/Hong Kong/68 virus stimulated a good antibody response to both the homologous strain and to the variant A/England/42/72. The reverse cross-reacting response has been evaluated by us in the experiments here reported.

Fifteen subjects ranging in age from 24 to 40 years and never treated with influenza vaccine were given two doses of inactivated influenza vaccine at two weeks' interval. Each dose contained A/England/42/72 400 IU and aluminium phosphate 1.75 mg. Sera were tested for antibody content to the homologous and to A/Hong Kong/68 virus

using the standard haemagglutination-inhibition test. The distribution of antibody titres for both viruses before and after each of the two vaccine injections is shown in the figure.

Fourteen days after the first dose a satisfactory increase in the antibody level against A/England/42/72 was observed in all the subjects and only two out of 15 did not show any increase in the antibody level against A/Hong Kong/68. The geometric mean titres were 1/114 and 1/68 respectively. The second dose elicited only a moderate further antibody response to both viruses; the mean titres rose to 1/173 and 1/84 respectively.

The results suggest that A/England/42/72 virus possesses a good antigenic potency; the first dose of the vaccine provokes a booster-like effect which might be due to preexisting A/Hong Kong/68 virus in circulation. The cross-reacting response suggests that the drift in antigenic content between A/Hong Kong/68 and A/England/42/72 viruses is moderate, at least from an immunological point of view.—We are, etc.,

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Lavatory Doors

SIR,—I was interested to read Dr. M. D. Begley's letter (29 September, p. 697) about

a patient trapped behind a lavatory door. Living on the Costa Geriatrica, I have come across this problem on numerous occasions, and so solid are the doors on old lavatories that they seem to have been built to withstand an elephant charge and can present a very real problem to the attending doctor.

I can assure Dr. Begley that there is no problem in having doors rehung so that they open outwards, and I have had altered all the lavatory doors in our 80-bedded convalescent home in which many of these unfortunate incidents have occurred. They are secured by a rotary latch operated from inside which also works a dial moving from "vacant" to "engaged." These can easily be opened from the outside with a small coin or a screw-driver. This method has been in use for some years and the expense of the alterations has been more than compensated for by the saving in broken doors. For doors as yet unmodified I keep available a 14-lb (6.4-kg) sledge-hammer. Three carefully aimed blows dislocate first the hinges, then the lock, so that the door can be removed bodily over the collapsed patient with the maximum speed and dignity.

I can recommend both these methods with confidence.—I am, etc.,

GRAHAM M. HUNTER

Bexhill-on-Sea,
Sussex

SIR,—Dr. M. D. Begley (29 September, p. 697) raises a real problem to which insufficient attention has been given. I fear that if we knew the number of lives that have been lost through delay in obtaining access in the circumstances he mentions, we should be very disturbed. Doors opening outwards are considered by many to be a serious hazard, but one wonders if a few bumps are not preferable to one lost life.

The problem of overcoming this difficulty at home is appreciated but surely, as a first step, good standard practice should be observed in hospitals and similar institutions. Alternatives are: (1) Door to open with conventional "engaged" bolt which can be operated by a small instrument or a coin from the outside. (2) Door opening inwards of stable-door type with a connecting bolt on the outside allowing entry over the lower half in an emergency. (3) Two-way hinge with removable jamb on the outside which can be lifted off and the door opened outwards. This system has been used in the new building at this hospital and we consider it to be the best method though it is comparatively costly.

Should not all of us look at this problem in existing buildings in an effort to remove this serious but avoidable hazard to life?—I am, etc.,

R. N. HUMPHERSON

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Psychogeriatric Ward for Mentally Disturbed Elderly Patients

SIR,—Dr. Felix Post's letter (29 September, p. 693) commenting on my paper (15 September, p. 574) can be answered with figures which are reasonably accurate, but because they were not precise they were not quoted in the original paper.

The admission rate to the psychogeriatric ward was approximately 150 patients per annum, almost all of them being patients with brain damage. In 1968 the psychiatric hospital discharged 15 cases of senile dementia with 10 deaths and discharged five cases of arteriosclerotic dementia with two deaths. In 1971 the psychiatric hospital admitted 22 cases of senile dementia, one case of arteriosclerotic dementia, and one case of "organic" dementia. In the same year they discharged 14 cases of senile dementia with 12 deaths and discharged one case of arteriosclerotic dementia with two deaths, while one patient with organic dementia died. I think these figures show that the vast majority of patients of this type were, in fact, being admitted to the psychogeriatric unit.

The other point made by Dr. Post about the rather high death rate is perhaps not sufficiently made clear in the original account. The deaths were very heavy in the group of patients who had severe physical disease quite apart from the mental disturbance, and I think if this group had been excluded and the death rate considered only in patients with brain damage and limited physical disease the picture would be somewhat different. The ward is equipped to deal with all forms of severe physical disease but unfortunately, in that age group, the mortality from physical disease alone is heavy.—I am, etc.,

D. M. PRINSLEY

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Prevention of V.D.

SIR,—A recent television programme on venereal disease turned to the question of prevention only in the last three minutes. The Director-General of the World Health Organization in his recent annual report¹ expressed alarm at the world-wide increase in V.D., now reaching crisis proportions. He appealed that those in a position to help should assert some influence against those pressures which encourage promiscuity.

Recent evidence² shows that cancer of the cervix is occurring in younger and younger women and is associated with sexual intercourse with different partners in adolescence (the younger the age the higher the risk). The recent figures for abortion³ and illegitimacy⁴ in the under-20s show no sign of improvement.

Is it sufficient for doctors to be merely pragmatic about all this? How many are aware of the many behind-the-scenes pressures on young people—pressures which actively and subtly encourage casual sexual intercourse? Health risks and facts on contraceptive failure are dissociated from these publicity pressures and this leaves young people unprotected from the misleading blandishments of their ignorance and vulnerability.

Luckily, doctors are still high on the list of trusted adults. Our responsibility and influence for this aspect of the health of teenagers (particularly girls) is a vital one at the present time.—I am, etc.,

ELIZABETH ELLIOTT

Wisbech, Cambs

- ² *British Medical Journal*, 1973, 3, 36.
³ *Registrar General's Quarterly Return for England and Wales*, No. 497, Quarter Ended March 1973. London, H.M.S.O., 1973.
⁴ Thompson, B., and Aitken-Swan, J., *British Journal of Preventive and Social Medicine*, 1973, 27, 137.

Evaluation of Oral Glucose Tolerance Test Results

SIR,—After correspondence from colleagues in various parts of the world about our paper prescribing the use of the H index for the interpretation of oral glucose tolerance test results (10 March, p. 573) my co-authors realize that some confusion may have arisen about the interpretation of H indices during pregnancy.

We quoted the range of values we regarded as "normal" and those indicating "suspicious" or "abnormal" responses; we also stated that the index might be a sensitive method for describing changes occurring in carbohydrate metabolism during pregnancy. We did not mean to imply from this that the categories described for males and non-pregnant females could be equally applied to healthy women during normal pregnancies. Indeed we have found that glucose homeostasis undergoes subtle but clearly defined changes during pregnancy, particularly during the last trimester, which make the non-pregnant categories unsuitable. This work is the subject of a paper to be published in the near future.¹

We appreciate that the majority of clinicians are dealing with non-pregnant subjects and for them the problem will not have arisen. To those who have an interest in the changes occurring to the oral glucose tolerance test during pregnancy we apologize for any misunderstanding which may have arisen—I am, etc.,

TOM LIND

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- ¹ Lind, T., Billewicz, W. Z., and Brown, G., *Journal of Obstetrics and Gynaecology of the British Commonwealth*. In press.

Who'd Be a Physiotherapist?

SIR,—Fewer physiotherapists in the future may be the answer to Dr. M. M. Salzmänn's question "Who'd be a physiotherapist?" (8 September, p. 544), unless their salaries are made a little more realistic. In 1971 there was one physiotherapist to every 7,500 adult hospital patients in England and Wales, and though since then the number of physiotherapists has been increasing it seems likely that this trend may be reversed. In spite of the satisfying work involved, an unreasonably low salary must surely make the profession less attractive, resulting in a lower intake of students, with consequently fewer qualified physiotherapists.

What happens then to the patients? Does one try to do a little for everyone or concentrate on those for whom most can be achieved (for example, patients with certain chest conditions) thus neglecting more chronic conditions and ignoring the preventive work? While some forms of physiotherapy may be inappropriate in the treatment of specific conditions on the grounds of their dubious effectiveness, there is a wide range of cases in which its value

is unquestionable. The use of physiotherapy should depend on medical grounds rather than on the unnecessary fluctuation in the number of physiotherapists resulting from lack of adequate remuneration.—We are, etc.,

MARGARET FARR
C. MCLEOD

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Injecting Hydroceles—an Unproved Treatment?

SIR,—In "Any Questions" (11 August, p. 344) the answer given concerning suitable substances for injecting into hydroceles is "none at all," while Mr. B. W. T. Pender's (22 September, p. 630) further advice concerning such injections is "don't do it." My own experience is completely contrary.

After complete aspiration, several solutions may be injected with success, some pain-producing, others painless. I have used this method in adults for over 20 years, extending the range from small hydroceles and cysts of the epididymis to those of moderate size (up to 300 ml) but have had less success with large ones of a pint and more. Earlier, one used quinine and urethane (now condemned) but I tried a solution which I have used for many years for varicose vein injections—phenol 2½%, glycerin 25%, and glucose 25% which is excellent. Small hydroceles need about 3-5 ml, moderate ones up to 12 ml, and large ones 15 ml, which may seem a large dose but one uses up to 15 ml intravenously at a session of varicose vein injections with no untoward effects. Pain can be readily produced by aspirating at the lower end of the scrotum, so that on standing the patient will ooze some of the injected fluid into the tissues, and aspiration should be made in the upper part of the swelling. The cannula must be well into the sac and not the surrounding tissues. This phenol solution may produce a short, minor discomfort in the scrotum or towards the iliac fossa, but usually the patient makes no complaint. At follow-up in 4-6 weeks there is always further fluid present, though less and darker. Aspiration is repeated and the injection may also be repeated. A further small accumulation of fluid usually absorbs satisfactorily. Sometimes a third injection may be necessary. Causes of failure are: too little sclerosant or its dilution by incomplete aspiration, or too large a hydrocele (pint-sized best treated surgically).

The number of patients treated is well into the hundreds; I always treat considerably more than 20 a year and there are patients whom my assistants have treated as well. Complications include sepsis in one case in which the trocar was put into the testis (incised), and haematocoele in two in which the trocar touched a blood vessel in the sac (evacuated). Failures have not been more than two or three in 100 and mainly with large hydroceles of a pint or more, for which I usually use surgery; also, multiple epididymal cysts are best excised.

The saving of time, trouble, and beds, for the patients and hospital personnel, has been considerable. Patients are grateful for a painless way of avoiding surgery and loss of earnings.—I am, etc.,

G. E. MOLONEY

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¹ W.H.O., *The Work of the World Health Organization in 1972*. Geneva, W.H.O., 1973.