

We consider that a self-administered questionnaire can be used to detect depression, although a single direct question such as we asked would not be very sensitive. However, it is noteworthy that 29% of the replies to the question were positive. There was no excess of positive replies in patients taking methyl dopa compared with patients taking other drugs. Patients who became severely depressed on any treatment regimen would have their treatment altered. These patients, however, represent only a small proportion of the patients studied.

Drs. R. P. Snaith and M. McCoubrie (personal communication) have given the Wakefield Self-Assessment Depression Inventory to 134 patients receiving methyl dopa, and have also failed to demonstrate an increase in depression while taking this drug.—We are, etc.,

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Anticoagulants in Infective Endocarditis

SIR,—The letter of Dr. C. P. Petch (1 September, p. 502) serves as a timely reminder of a lesson established in the past medical literature that anticoagulants are contraindicated in infective endocarditis.^{1,2} However, a survey of current textbooks of therapeutics fails to reveal a reference to this danger and Dr. G. W. Hayward's recent review of the subject (23 June, p. 706, and 30 June, p. 764) makes a similar omission. Moreover, it has recently been suggested that anticoagulants "should be used for the same reasons that they are administered to persons who do not have endocarditis."³

For these reasons any reference to this hazard⁴ must serve as a most urgent reminder of the earlier but largely forgotten opinion that anticoagulants should remain contraindicated in this disorder.—I am, etc.,

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Type IV Hyperlipidaemia in Cord Blood

SIR,—I would certainly agree with Dr. F. M. Martins and others (8 September, p. 544) about the importance of early detection of hyperlipoproteinaemia that is liable to lead to early coronary artery disease. If therapeutic measures are to be effective it would seem probable that the earlier these are started the greater the chance of success. The authors imply, however, that it is possible to detect type II hyperlipoproteinaemia by serum cholesterol measurements at birth. A recent longitudinal study of 302 infants¹ demonstrated that unfortunately this is not reliable. Only five of 30 babies whose cord-blood cholesterol level exceeded 100 mg/100 ml had a serum cholesterol above 240 mg/

100 ml at the age of 1 year. With further investigations none of these had familial hypercholesterolaemia, whereas the only child in the study who was found to have the condition had a normal cord-blood cholesterol level. Kwiterovitch *et al.*² have also shown that the measurement of cord-blood cholesterol may be misleading in the detection of familial hypercholesterolaemia. However, they suggest that if a parent has known type II hyperlipoproteinaemia measurement of cord-blood low density lipoprotein (LDL) cholesterol may be a more useful predictive investigation. Of 19 babies examined at birth and again between the ages of 1 and 2½ years, the cord-blood LDL cholesterol had predicted the presence or absence of hyperlipoproteinaemia correctly in all but one.

It is surprising in the light of previous studies^{3,4} that Dr. Martins and his colleagues should have found such a high proportion of babies in Lisbon with cord-blood triglyceride levels above 150 mg/100 ml. It will be of great interest to hear of the future lipid investigation of these six babies and their families and also to learn whether a similar proportion are found when a larger number of babies have been examined.—I am, etc.,

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Sterility after Vasectomy

SIR,—May I comment upon the interesting dialogue (22 September, p. 634) following Mr. D. Urquhart-Hay's paper (18 August, p. 378) on the subject of eufflavine irrigation after vasectomy as an alternative to subsequent semen analyses. Like most problems in human experience, I suggest that compromise is the best solution. Therefore, before tying both ends of the vasa during vasectomy, 2.5 ml of eufflavine should be injected slowly into the proximal end and the patient told not to void urine for 2½-3 hours postoperatively (this latter advice was not given by Mr. Urquhart-Hay). This gives the eufflavine adequate time to kill the sperms. Subsequently, semen examination at four, eight, and 12 weeks should still be performed. I have examined fresh semen which has been treated with 1/1,000 eufflavine and kept at 30°C in a water bath for 20 minutes. After 10 minutes all the sperms were non-progressing, with the majority dead (using eosin-nigrosin stain technique). After 20 minutes no living sperms were visible.

May I ask what evidence Mr. A. Halim and Professor J. P. Blandy (14 July, p. 110) have that a non-motile sperm (excluding one whose non-motility is due to freezing) can cause fertilization of an ovum with subsequent pregnancy? Or are they suggesting that non-motile sperms can become motile again within the female? With reference to frozen sperm (?by liquid nitrogen), are they suggesting that non-motile sperms are causing subsequent pregnancies?

Many authors have referred to the possible recanalization of a vas, at about three

months post-vasectomy, as an explanation for reappearance of sperms in the semen. As approximately 3 cm of each vas is (or should be) removed, this requires a growth rate of 1 cm per month. Can any human tissue grow (within the body) at this rate?—I am, etc.,

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SIR,—Mr. A. Halim and Professor J. P. Blandy (14 July, p. 110) state that sperms in frozen semen used for artificial insemination are never motile after thawing. Six months ago I destroyed some ampoules of donor semen, in 10% glycerin, which was frozen and stored in liquid nitrogen in early 1969. This was thawed in water at 37°C and in each case, when examined under the light microscope, showed many thousands of actively motile sperm. Dr. Margaret Jackson confirms my findings.—I am, etc.,

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SIR,—A technique for achieving immediate sterility after vasectomy, described in Mr. D. Urquhart-Hay's paper (18 August, p. 378), represents a most important advance. By eliminating, as well, the need for post-operative sperm counts, the technique should make vasectomy even more popular as a method of birth control.

It does, however, depend on acceptance of the proposition that non-motile sperms, as seen in fresh specimens of semen post-operatively, are incapable of producing a pregnancy. Dr. L. N. Jackson (15 September, p. 589), like Mr. A. Halim and Professor J. P. Blandy (14 July, p. 110), has misgivings about this proposition.

The time has surely come when this matter should be resolved. On the one hand we have speculations—that live sperm might be present but not be seen; that some sperms might have been motile at the time of ejaculation; that they might become motile again later; or that some non-motile sperms are not quite dead and in some way might produce a pregnancy. These speculations are not supported by any evidence that pregnancies have occurred in such circumstances. Nor have any cases been reported in the literature. On the other hand, we have evidence in the experience of those¹⁻³ who have been giving patients an "all clear" in spite of the persistence of non-motile sperms. Again, no pregnancies have been reported as a consequence of this advice being given.

Are we to prefer speculation as to what might happen to evidence as to what does happen?—I am, etc.,

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SIR,—We have been interested in the various accounts recently published of irrigating the vas with various liquids at vasectomy.¹⁻³ Each of these authors has mentioned introducing the fluid via a fine polyethylene tube, needle, or cannula inserted