

There is some argument about the standard of cross-matching which should be adopted for non-urgent transfusions. The expert can use almost any method he likes with safety, but the occasional transfusionist should adopt one of the standard tube methods, since he is less likely to make mistakes with them than with any other. I would suggest a cross-match in saline at about 20° C. (room temperature) and by the Sheffield technique in albumin, at 37° C. A 37° C. incubator and a small centrifuge are essential, and no adequate blood grouping can be done without them. The recommended procedure is:

Place two tubes in each of two racks, labelling one of each pair "test," the other "control." Into each "test" place 3 drops of recipient's serum, into each "control" 3 drops of saline.

Into each tube place 3 drops of an approximately 5% suspension in saline of donor cells which have been removed from the bottle or pilot bottle with a sterile Pasteur pipette and washed once in saline. Leave one rack at room temperature; place the other in the incubator for 1½ hours. After 1½ hours remove from the incubator without shaking, and remove as much as possible of the supernatant serum and saline: replace it with 6 drops of 20% bovine albumin solution without disturbing the sedimented cells. Return to the incubator for half an hour. At the end of a further half-hour—that is, two hours from the beginning—remove samples from the tubes and examine microscopically.

If the tubes marked "test" show even a few clumps of cells, while those marked "control" show more, then the blood should be regarded as incompatible. A number of samples known to be incompatible should be tried at leisure, using smaller proportions of serum, so that the appearance of incompatibility becomes familiar.

But would it not be possible to send all non-urgent transfusions to a large local hospital or to the regional depot for cross-matching? Were I the writer of this question, I should be extremely worried by the lack of facilities, and one of my first actions would be to ask the regional transfusion director to call and advise me on the best use of the facilities which were available. It is definitely not justifiable for an "occasional transfusionist" to use a saline tile cross-match method for "non-urgent" transfusions.

#### Atropine and Neostigmine after Relaxants

**Q.**—It is customary when counteracting relaxants at the end of an operation to give intravenous atropine some minutes before intravenous neostigmine. Is there any experimental evidence to suggest that the speed of action of these two drugs is in fact different, so that they may not be given together?

**A.**—The practice of administering atropine some 10 minutes before neostigmine, when reversing the effects of a curare-like drug, is an attempt to avoid the coincidence of any initial bradycardia due to atropine and the bradycardia due to neostigmine. It is certain that a brief bradycardia generally precedes tachycardia when atropine is administered hypodermically. But there is some doubt whether this happens when the drug is injected intravenously. Indeed, one author<sup>1</sup> is emphatic that it does not. There is therefore some experimental evidence to suggest that the danger of giving atropine and neostigmine together is not a great one.

Any difference in the speed of action between atropine and neostigmine is probably not an important consideration in this connexion, since both take about five minutes to reach their maximum effect when given intravenously.<sup>1,2</sup>

#### REFERENCES

- Hunter, A. R. (1953). *British Medical Journal*, 1, 640.
- Shearer, W. M. (1951). *Anaesthesia*, 1951, 6, 76.

### NOTES AND COMMENTS

**Fetishism.**—Dr. DORIS ODLUM (London, W.9) writes: I have read with interest the answer to the question on fetishism ("Any Questions?" January 15, p. 178). In the course of the answer, however, it is stated that this appears not to occur in women, but from my own clinical knowledge I can state that in fact it does do so. One of my patients—a woman in the forties of the highest character and a teacher of English—was deeply disturbed by feelings of guilt because she had a definite orgasm whenever she

saw a pair of eye-glasses on a table or in any place where light was reflected on them. She found it a great temptation to put glasses in such a position and from time to time did in fact do so, but her most satisfactory orgasm came when the situation arose by chance. In another case a woman had strong sexual sensations whenever she touched certain types of fur, notably sealskin, moleskin, or squirrel, or when she handled certain types of velvet. In another case orgasm always resulted from the sight of a riding whip or cane, associated with masochistic fantasies. None of these cases was suffering from any kind of emotional disturbance and they were all making a good adjustment to life. I have also known of other cases where the women were happily married and were all well adjusted both to their husbands and children and to life in general. The condition is not necessarily due to any morbid tendency produced by lack of emotional satisfaction, but rather represents an alternative or supplementary form of sexual gratification. I have also had cases where some girl children as well as boys had obvious orgasms when they were sucking a blanket before going to sleep and who insisted on being allowed to suck the blanket before they would settle down at night, and a number of children of both sexes show obvious evidence of rudimentary orgasm when they smack or hug a doll or teddy bear. I have not heard of a case in which a woman has gone so far as to practise fetishism in public, and in the cases that I know of they are extremely loath to speak of it either because they feel guilty about it or because they realize that it would give rise to moral and social condemnation even though they themselves did not feel any guilt. This may be the reason why its existence has not been generally recognized.

**Drugs and Fertility.**—Mr. HOWARD G. HANLEY (London, W.1) writes: The answer to the question on this subject ("Any Questions?" January 8, p. 118) states, "... there seems good evidence that the sulphonamides in therapeutic doses may suppress temporarily the development of spermatozoa within the testis and so lead to impaired fertility." I have been unable to find the original reference in support of this belief, but have accumulated some evidence to show that it is untrue. I have carefully followed up 21 cases of pyospermia treated with sulphathiazole, "sulphatriad," or "gantrisin" in large and sometimes prolonged dosages, and, although one can expect the sperm motility to improve when the pus cells are cleared, in no case has the count been reduced or impaired in any way. The two cases which have been referred to me as showing reduced spermatogenesis following sulphonamide therapy both gave a clear history of a relatively severe fever (influenza with quinsy; lymphangitis) which necessitated the giving of the sulphonamides, and I suspect that it was the hyperpyrexia or the debility, not the sulphonamides, which were responsible for the temporarily impaired fertility. I also suspect that smoking has been blamed in the same unscientific manner, and whether spermatogenesis can be depressed by nicotine *per se* rather than by the various pathological disturbances attributed to excessive smoking is a debatable point. The opening sentence of the answer to the question contains the crux of the matter, "There have been few, if any (my italics) systematic studies of the effect of drugs on fertility, and consequently knowledge on this subject is scanty."

OUR EXPERT writes: Mr. Hanley's comments may well be quite justified. The first sentence of my answer to which he draws attention was indeed intended to contain the crux of the matter.

**Corns Between the Toes.**—Dr. C. GUY MILLMAN (Morpeth, Northumberland) writes: May a psychiatrist get down to earth and suggest that animal wool is preferable to the gauze advised in the reply to the question about corns between the toes ("Any Questions?" January 1, p. 56)?

**Correction.**—In the *Journal* of January 8, p. 111, it was recorded in error that the University of Oxford had granted leave of absence to Professor R. R. Macintosh for three months from January 1, the decree having been withdrawn before Congregation on November 30, 1954.

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