p 147). While I welcome the intention of the article in drawing attention to the patchy and faltering implementation of the 1970 Chronically Sick and Disabled Persons Act in many parts of Great Britain, I am astounded at the lack of discussion of the real progress that has been made by OUTSET, among others, in producing and testing efficient methods of identifying the "hidden handicapped" in the community. Your editorial asks, "How can we find the 'hidden handicapped'?" and suggests a number of methods, many of which have been looked into and shown to be inadequate. The only method found by us to be reliable is to find out by door-to-door survey where handicapped people are, and follow this up with an in-depth interview of each handicapped person identified in order to ascertain difficulties and requirements.

OUTSET has been involved in over 20 surveys of this nature since the passing of the 1970 Act, and more recently has been able to improve techniques substantially by marrying our survey methods to the classification of handicap pioneered by Dr Margaret Agerholm. We have found that our techniques produce a variety of useful information, as well as putting individual handicapped people in touch with relevant services. Currently, we are carrying out, among other projects, a major survey of the whole of Northern Ireland, aiming to obtain a response from each household in the province, and to interview 50 000-70 000 handicapped people thus discovered.

I would have thought that the already encouraging success of this venture is in itself a worthy answer to your question. It is with sadness therefore that I observe your reluctance to recommend or indeed mention it.

ALAN WHITEHEAD

Craven Street,
London WC2

Acute poisoning with Distalgesic

SIR,—So Dr J A J H Critchley and others (3 February, p 342) wish to start a nationwide campaign on the use and restriction of Distalgesic. Is this not the tail wagging the dog? At least with the campaign on barbiturates, effective and safer alternatives were available. Distalgesic is widely and correctly used by vast numbers of patients, particularly with rheumatic diseases. I would estimate some 40% of my patients have taken Distalgesic at some stage: I am unaware of any patient who was unable to give up Distalgesic when the clinical condition had improved and I am unaware of any patient who has become addicted to it. I do not consider that continuing Distalgesic in the medication of an ongoing painful condition is addiction. No patient of mine has yet taken an overdose. Although there may not be adequate double-blind controlled trials proving that Distalgesic is superior to other analgesics, most of the patients who remain on Distalgesic infinitely prefer it to the other analgesic drugs they have tried and that seems a reasonable basis on which to continue prescribing Distalgesic.

Perhaps those who feel strongly about drug abuse (and I have sympathy with their view) should devote their missionary zeal to changing the nature of man or the world, as curbing the use of Distalgesic will merely transfer drug abuse to another easily available drug, as happened when phenacetin was removed from aspirin, phenacetin, and codeine tablets.

The incidence of suicide has not greatly changed since coal gas was withdrawn: people merely use different agents. On epidemiological grounds I wonder whether Dr Critchley *et al* are correct. Distalgesic is very widely prescribed and the admission of 130 cases of self-poisoning in a year may only reflect the frequency with which Distalgesic is prescribed, rather than suggesting that it is the most popular drug for drug abuse.

It is remarkable how just a little abuse by a few can affect thousands of satisfied users—as in the case of the paternoster lift at Northwick Park, which has been out of use for six months as a result of being abused by a skylarking juvenile (delinquent) unconnected with the hospital. Many have suffered gross inconvenience meanwhile.

J M GUMPEL

Northwick Park Hospital and Clinical
Research Centre,
Harrow, Middx

Storage and cooking of poultry

SIR,—Readers who consulted your leading article (18 November, p 1385) on the storage and cooking of poultry will have had a Merry Christmas and escaped a food-poisoning infection. In order to do so, however, they must have risen inordinately early on Christmas Day. Your advice to cook a large turkey of, say, 20 lb weight for 30 minutes per lb at 200°C (400°F) in a preheated oven implies a cooking time of 10 hours. At this temperature the bird would be well cooked—some might claim too well cooked, but at least it would be safe.

Those who do not read your journal or were too lazy to get up early on Christmas morn could follow the advice of the British Turkey Federation, circulated by the DHSS in HN(77)190, and lie in bed with a clear conscience. Their bird of the same weight required only 10½ minutes per lb at 177°C (350°F)—a total cooking time of only 3½ hours and at 23°C lower temperature.

Those of us who are asked to give advice find it difficult to reconcile these two statements. Infections due to salmonella and *Clostridium perfringens* continue to be associated with the eating of turkeys. We need evidence to support one or other of these authorities. Is such evidence available?

A E WRIGHT

Director,
Public Health Laboratory, Gloucester

A WITHNELL
Area Medical Officer,
Gloucestershire

Gloucester

How to use a library

SIR,—Medical librarians are nearly always pleased at any attempt to publicise the collections in their care, or the services they try to offer; and most of us these days can do with all the help we can get—but some of us will have read Dr M G Timbury's article (27 January, p 252) with some disappointment. Although I realise that this presented the views of one departmental librarian, and that it did contain some useful information, the role of the medical librarian was dealt with in four lines.

The task of carrying out detailed searches of an ever-expanding literature, with all its complexities, is one many of us would regard as

something only trained, skilled, and experienced librarians can do. This is not to say that readers cannot often help themselves; but medical librarians are in a special position because, unlike doctors, they are able to concentrate on the literature "for itself alone" and are not directly concerned with its implementation—in other words, they are able to act as a bridge between the literature and the reader.

Librarians are used to being a somewhat misunderstood profession and are accustomed, on the one hand, to having effusive praise for merely telling a reader where the *BMJ* is located and, on the other hand, to meeting a lack of understanding of the many techniques and often considerable experience involved in dealing with highly complex bibliographical inquiries. Nevertheless, some readers in the past have recognised the role we play; and in 1953 Sir Cecil Wakeley, the president of the First International Congress on Medical Librarianship, reminded us that "some of the finest consultants available are to be found in medical libraries"—meaning medical librarians. Many of us would be quite content to accept this evaluation of our work.

In recent years some valuable papers by medical librarians have appeared, and one could cite the excellent series by Miss F M Picken.^{1,2} I do not wish to comment on Dr Timbury's recommendations or the references she gives in further detail but I was surprised that, although she cited Mr L T Morton's *Use of Medical Literature*, 2nd edition, 1977, she did not refer to the other book by one of our most distinguished medical librarians—*How to Use a Medical Library*,³ which first appeared in 1934.

P J BISHOP

The Library,
Cardiothoracic Institute,
London SW3

¹ Picken, F M, *Teach-In*, 1974, 3, 302, 237, 297, 427, and 506.

² Picken, F M, *Hospital Update*, 1975, 1, 59 and 563.

³ Morton, L T, *How to Use a Medical Library*, 6th edn. London, Heinemann, in press.

SIR,—I read with interest the excellent article by Dr Morag Timbury on "How to use a library" (27 January, p 252). As she points out, she has presented her own viewpoint, but has nevertheless covered sufficient points to provide an adequate introduction to library use.

Might I, however, elaborate on just a few of her points? *Index Medicus* is all Dr Timbury says it is—but it is also something more. For the last few years it has included a selection of monographs—mostly conference proceedings and the like, listing the individual papers by author and subject. For those who may wish to know whether a particular conference has reached publication, there is a useful publication called *Directory of Published Proceedings: Series SEMT* (science, engineering, medicine, and technology). The National Library of Medicine *Current Catalog* is indeed a useful bibliography. I have found that its greatest asset is its listing of US Government publications.

With regard to Medline, Dr Timbury suggests that most main libraries have direct access to the computer. There are many which do not. But even the smallest medical libraries usually have access to the postal service of Medlars, which, although somewhat slower, is preferable on occasion to manual searching. Perhaps it should be mentioned that computer searches are an expensive pastime and should be reserved for the more complicated searches.

I entirely endorse her last point, about illicit "borrowing." But here might I suggest that doctors can be of help to the library if they are willing to donate journals to which they subscribe, when they have finished with them. Finally, as Dr Timbury says, get to know the staff of your library. They are there to help you.

E M EDWARD

Warwickshire Postgraduate
Medical Centre,
Coventry

How to choose and use a calculator

SIR,—I am sorry that Dr T D V Swinscow in his excellent article on how to choose a calculator (3 February, p 326) does not quite do justice to reversed Polish notation (RPN) and to the advantages of programmable instruments even for those who, like me, regard themselves as mathematically naive.

As to the first, while the debate about RPN versus algebraic notation is never ending, there are clear logical advantages in the former which carry over into the whole class of problems encountered in medicine. I do not agree that RPN is named after a man, but that is unimportant. As to the second, it is a general principle of the use of calculators that the escalation rule operates—namely, that one buys a machine because it has certain properties (for example, one memory) only to recognise that if it had a bit more (for example, eight memories) it would be that much more useful. The availability of programming, while it could threaten some by its alien nature, will stimulate many more. I should like to say too that those who are contemplating a calculator that will do their statistics, their accounts, and their stock-market transactions need a programmable instrument (whether magnetic card or not is a subsidiary consideration) to avoid Dr Swinscow's Coleridgean "person from Porlock" syndrome. They will find that it opens new fields and is not difficult for the logically as distinct from mathematically equipped individual to handle. In my unit we have gone from one non-programmable to four programmable machines in three years.

HUGH DUDLEY

St Mary's Hospital,
London W2

SIR,—In his otherwise excellent article on choosing and using a calculator, (3 February, p 326), Dr T D V Swinscow has made a serious omission by not mentioning that most calculators are now available as liquid crystal display (LCD) models, which give 1000 to 2000 hours—that is, several years—of daily use on one set of batteries. The problem of failing batteries in the middle of Africa and the development of internal faults in rechargeable batteries are now things of the past.

M J BALL

Hertfordshire Area Health Authority,
Hemel Hempstead, Herts

A "side benefit" of metronidazole?

SIR,—Metronidazole currently finds extensive use in the prophylaxis and treatment of anaerobic wound infections. We would like to report a case so treated with an unusual side-effect or "side benefit."

The patient was an 81-year-old man, admitted

for repair of a recurrent right inguinal hernia and of a left inguinal hernia. He had suffered from a chronic skin disease for the previous 15 years, which had resisted all forms of treatment. A skin biopsy in 1972 was reported as "prurigo nodularis" and he had subsequently been treated symptomatically with a variety of medicaments. Currently he was on Synalar (fluocinolone acetonide) ointment and two Vallergeran (trimeprazine tartrate) tablets at night. He was covered with elevated, indurated, scabbed, and ulcerated lesions, which were extremely irritable. These were more marked over his extremities. Shortly after his admission he developed copious diarrhoea, which on investigation proved to be due to an intussuscepting neoplasm of the transverse colon. With a view to resection, he was started on bowel preparation, consisting of castor oil, enemas, and metronidazole. Within 24 hours of starting the metronidazole he announced that his itching had gone. Over the course of the next week all his scabs cleared completely and the lesions became less prominent. He continued itch and scab free until his discharge.

Perhaps metronidazole has found another niche into which it can usefully be slotted—an anti-itch niche.

S M WOOD
SISTER JOSEPH
L J CHALSTREY

Hackney Hospital,
London E9

Non-motile sperms after vasectomy: do they matter?

SIR,—The papers of Mr R P Marwood and Dr Valerie Beral, and Dr Ian S Edwards and Mr John L Farlow (13 January, p 87) draw attention to the tiresome but important question of "clearance" after vasectomy.

Small numbers of motionless sperms linger in the nooks and crannies of the seminal vesicles and the ampullae of the vas, and can be found in the centrifuged deposit of the semen, long after vasectomy. Some of the medical defence organisations take the view that patients must continue to provide specimens of semen until not a single sperm, however dead, can be found. This seems to be because it is feared that a judge and jury might conclude that an unwanted pregnancy could have been caused by such a sperm, and the doctor who advised his patients that it was safe to discontinue using other contraceptive methods might be considered negligent. Absurd though this opinion must be, it is good news to see objective evidence to contradict it. One can, of course, always see if the motionless sperms take up vital dyes such as eosin or trypan blue, to make quite sure that they are dead and not just sleeping.

JOHN BLANDY
H R ENGLAND
MARIAN BARNES

Department of Urology,
London Hospital Medical College,
London E1

SIR,—While continued presence of immotile sperms in postvasectomy seminal specimens is unlikely to cause pregnancy, Dr Ian S Edwards and Mr John L Farlow (13 January, p 87) have not proved their hypothesis. Immotile sperms may still remain viable and may have a normal oxygen consumption.¹ When immotile sperms persist it would be useful, and may become necessary, to assess the viability of the sperms by staining the centrifuged sample by, for example, Eliasson's modification of Dougherty's technique,^{2,3} using 1% eosin and 10% nigrosin.

The adoption of this technique may help to establish the new criteria for seminal clearance sought by Mr R P Marwood and Dr Valerie Beral in the same issue (p 87). It would certainly alleviate the patient's anxiety and prevent possible medicolegal complications where persistent immotile sperms are shown to be non-viable.

P M HENDY-IBBS

Department of Obstetrics and Gynaecology,
Jessop Hospital for Women,
University of Sheffield

¹ Eliasson, R, *Biology of Reproduction*, 1970, **3**, 369.
² Dougherty, K A, *et al*, *Fertility and Sterility*, 1975, **26**, 700.
³ Eliasson, R, *Fertility and Sterility*, 1977, **28**, 1257.

SIR,—The short reports by Mr R P Marwood and Dr V Beral, and by Dr I S Edwards and Mr J L Farlow (13 January, p 87) on the importance or otherwise of a few non-motile sperm go a long way to confirm the clinical impression of many of us that there is virtually no chance of a pregnancy with such a seminal analysis.

Despite this impression most vasectomists "play it safe"—and indeed this is the advice of the Medical Defence Union—by waiting for two completely clear specimens. In view of this it is with considerable reluctance that I must rock the boat by reporting a recent case.

I performed a vasectomy on a 45-year-old man in February 1978. He produced specimens of semen for analysis at 12 and 14 weeks and neither of these showed any sperm. We then told him that he was sterile, and his 35-year-old wife stopped taking the contraceptive pill. A 10-week pregnancy was confirmed by ultrasound on 1 November and she underwent a vaginal termination and laparoscopic sterilisation. A further seminal analysis of a fresh specimen in October showed less than one non-motile spermatozoon per high-powered field. There can be few readers who would not jump to the same conclusion that I did—that this lady must have had extra-marital intercourse; but subsequent inquiries in strictest confidence by both myself and the gynaecologist convinced me that this was not so. I accept that this must be a most unusual case and that it raises more questions than it answers, but in the light of it I feel myself that we are not in a position to be certain that we can ignore the odd non-motile sperm.

ROBERT WHITAKER

Department of Urology,
Addenbrooke's Hospital,
Cambridge

Detection of deep venous thrombosis by ^{99m}Tc-labelled red-cell scans

SIR,—We read with interest the paper by Dr W Beswick and others (13 January, p 82) concerning the detection of deep venous thrombosis by scanning the technetium-^{99m}-labelled red-cell pool. The authors conclude that this technique "is clearly an acceptable alternative" to conventional phlebography and preferable to other diagnostic techniques. We would like to question this conclusion on the following counts.

Firstly, the patients chosen for investigation were highly selected. A high clinical diagnostic rate of 72% suggests that they were suffering from major venous thrombosis. This is confirmed by reference to table I, which shows that 19 out of 21 patients had thrombus involving the proximal veins. In only two