ing. Medical journals in particular should stop immediately the implicit advertising of alcohol which often appears in their pages concerned with eating out and such recreations. It is not long since in Birmingham the BMA itself arranged a whisky tasting evening.

On the other hand, with heroin we have created a "pushers' market," and our methods for handling this problem are those which have proved disastrous in America in respect of the prohibition of alcohol. In the case of alcohol and of heroin we should set about creating a proper social atmosphere and the attitude that the use of these drugs is despicable. The use of alcohol being so disastrously established in society, we should try to check its use by severe fiscal measures and by legislation against any form of advertising. The so-called hard drugs might best be made available at a cost which will not provide anyone with a motive for pushing; they should be sold unromantically packaged in containers marked "drugs for dopes," and it should be made as inconvenient to obtain them as is compatible with the determination not to create an interest for drug pushers. Individuals have to be responsible for themselves and take the consequences of their foolish behaviour. At least a heroin addict is not likely to cause the death of anyone except himself and in this differs radically from the alcohol consumer.

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Vancouver style

SIR,—Most authors and readers will be grateful that so many journals are adopting a uniform style; but is it too late to plead for the sensible usage of the *Journal of Paediatrics*, which gives a list of all abbreviations used in the text in a box on the first page of each paper?

This may be an extra chore for authors, but it is a tremendous boon for readers, particularly those who need to skim through a large number of journals to pick out which papers need to be read carefully.

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Disinfection with glutaraldehyde

SIR,—Following the expiry of the patent on 2% activated alkaline glutaraldehyde, a number of other glutaraldehyde products have appeared on the market. Simple tests suggest that some of these products are corrosive to certain metals and may cause damage to other materials. Glutaraldehyde is commonly used to disinfect expensive instruments—for example, endoscopes—and it is important to check with the instrument manufacturer the suitability of the compound before use.

Glutaraldehyde compounds are either acid or alkaline and may or may not require activation. Although all seem to be effective against vegetative organisms, and claims made by manufacturers for sporicidal activity are generally acceptable, the acid glutaraldehydes tend to be less active at room temperature but more stable than the alkaline. Claims of activity remaining for 14 to 28 days after activation depend not only on stability but on

the extent of dilution, the addition of organic materials, and pH changes. Continuous heavy use of a disinfectant solution for 28 days would considerably increase the risk of inactivation. We believe that repeated use of the same disinfectant solution is undesirable, but recognise that it may be necessary on grounds of expense. We are loath to recommend the repeated use of a solution, however stable, for more than seven to 14 days.

We should also like to remind readers that most reusable items, other than those used in surgery such as laparoscopes and arthroscopes, do not require sterilisation. Most equipment, apart from flexible fibreoptics, can be disinfected by heating to over 70°C, either in a washing machine or in a low-temperature steam autoclave without formaldehyde.

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Safety of piped medical gases and electromedical equipment

SIR,—Following reports on accidents with anaesthetic and pipeline equipment at the Westminster and other hospitals, there has been much activity by many people intending to improve the safety of design and service maintenance of this equipment throughout the country. The new British Standard for pipeline terminal outlets, which are known as Mark 4, has been published and one hopes that this will improve safety.

Up and down the country many hospital engineers have already sought to make improvements of the piped medical gas installations by means of installing isolating valves and making other alterations. The awareness of the importance of tightening up on the efficiency of service maintenance of anaesthetic and allied equipment has been noticed in the engineering, supplies, and medical disciplines. Unfortunately in some areas, and with the best of intentions, hospital engineers have made decisions affecting the policies concerned in obtaining these improvements without consultation with the medical and nursing staff who actually use the equipment.

It should be understood that final responsibility for what happens when a patient is treated rests with the person prescribing and administering such treatment. The final responsibility for the policies aimed at achieving safety and any changes in these policies must therefore be made either at the instigation, or with the prior approval, of these clinicians. Few of the recent publications give didactic advice on the precise nature of the interface between the clinician and the engineer. Only too often a glib statement that circumstances will vary from one hospital to another has been made, and the responsibility is thereby avoided. I feel that it should be accepted that a named member of the medical staff for each hospital or discipline therein should at all times be consulted whenever a decision with regard to the policy, rather than mere supervision of service maintenance, is considered.

At the time I write this letter the British Standard No 5724 is likely to be published in the very near future. This standard refers to safety of electromedical equipment. It would be well to point out that the publication of a

new standard does not on its own require that all electromedical equipment in hospitals must be immediately made to comply with it or be replaced. There will be need for considerable discussion between the medical and engineering disciplines in order to decide what action, if any, needs to be taken to bring existing equipment to a safe standard. Those items which comply already with either HTM8 (Hospital Technical Memorandum No 8) or the recommendations of IEC 601/1 (International Electrotechnical Committee No 601/1) should require no alteration.

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Non-motile sperms persisting after vasectomy: do they matter?

SIR,—We would like to comment briefly on points raised by Professor J P Blandy and others (24 February, p 552) about our paper (13 January, p 87).

Firstly, the use of vital dyes: these dyes may indeed indicate that some non-motile sperms are not quite dead, but this is a needless elaboration. If non-motile sperms do not, when put to the test, cause pregnancies their ability or inability to consume oxygen or take up vital dyes is unimportant.

Secondly, Dr P M Hendy-Ibbs (24 February, p 552) correctly states that we have not proved our hypothesis. This is a philosophical objection: we deliberately formulated our hypothesis in Popperian¹ terms. If deliberate attempts have failed to disprove it then it is tentatively acceptable. We claim no more and would welcome attempts by others to falsify it.

Finally, the wife of Mr R H Whitaker describes a patient (24 February, p 552) whose wife became pregnant a few months after his postvasectomy seminal assays had twice shown complete azoospermia, with a few non-motile sperms being found three months after conception. This is a classic example of temporary recanalisation, as described by Marshall and Lyon,² in all of whose cases the vasa had been ligated with non-absorbable sutures. It would be of interest to know whether that also applies to Mr Whitaker's case. However, apart from confusing the issue, such a case is irrelevant to the question as to whether non-motile sperms can cause pregnancies.

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¹ Popper, K P, *The Logic of Scientific Discovery*. London, Hutchinson, 1975.

² Marshall, S, and Lyon, R P, *Journal of the American Medical Association*, 1972, **219**, 1753.

*.*This correspondence is now closed.—Ed, *BMJ*.

Induction of labour and postpartum haemorrhage

SIR,—Mr P R S Brinsden and Mr A D Clark (23 September, p 855) and Mr I Z MacKenzie (17 March, p 750) have reported increased incidences of postpartum haemorrhage following induced labour compared with spontaneous labour. In contrast to these reports, we found, in a randomised controlled trial,¹ that patients

who were induced at term had a significantly lower blood loss at delivery than a group who were left beyond the 41st week to go into labour spontaneously. We attributed the lower blood loss after induction to the simple expedient of maintaining the oxytocin infusion for at least one hour after delivery.

One possible reason for the apparently conflicting results is that Mr Brinsden and Mr Clark and Mr MacKenzie are not comparing like with like. By going into spontaneous labour, patients may be demonstrating the essential "normalness" of their uterine activity whereas patients who fail to go into labour spontaneously may be declaring an abnormality of uterine function. A clue to this abnormality may come from Mr MacKenzie's own data when he shows that the use of prostaglandins prior to induction reduces the postpartum haemorrhage rate. It may well be that patients who fail to start labour spontaneously do so because of deficient prostaglandin production and that it is this failure, rather than induction itself, which is responsible for the reported increase in postpartum haemorrhage. It would seem to be essential that conclusions should be drawn from prospective controlled trials rather than from retrospective uncontrolled data.

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¹ Cole, R A, Howie, P W, and Macnaughton, M C,
Lancet, 1975, 2, 767.

Concurrent steroid and rifampicin therapy

SIR,—We read with interest the report by Dr W Hendrickse and others (3 February, p 306) of rifampicin-induced non-responsiveness to prednisolone in the nephrotic syndrome. We have recently observed a similar phenomenon in a patient being treated for tuberculous pericarditis.

A 21-year-old Pakistani presented with a 48-hour history of confusion. For about eight weeks he had been pyrexial, anorexic, and losing weight. On examination he was delirious with a temperature of 41°C and signs of bilateral pleural effusions and cardiac tamponade. After pericardial and pleural aspiration, chemotherapy was started with rifampicin, ethambutol, and isoniazid. Tubercle bacilli were subsequently grown from the pericardial fluid and were fully sensitive to all three drugs. Because of a continuing high fever and reaccumulation of his effusions, prednisolone was added on the 16th day of treatment and the dose adjusted to the minimum which would control the fever. From the 21st to the 27th day of treatment 30 mg of prednisolone was effective but 25 mg was not; thereafter control was lost and the dose of steroids had to be increased so that by the 40th day of treatment 40 mg of prednisolone was required. It was not possible to reduce the dose of prednisolone without precipitating a considerable rise in temperature until the 79th day of treatment. At this time the corticosteroid was gradually reduced and the patient now remains afebrile on 10 mg daily.

Although the patient's condition did not allow us to perform pharmacokinetic studies, we feel that the circumstantial evidence points strongly to increased metabolism of prednisolone by rifampicin-induced microsomal en-

zymes. We agree with the authors that this property of rifampicin should be more widely recognised in relation to glucocorticoid therapy.

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Service for psychiatrically ill doctors?

SIR,—I read with regret recently that yet another colleague had taken his life by his own hand. Surely it is an indictment of a caring profession that so many of our own members take this course of action. Doctors are vulnerable to psychiatric illness, and yet the profession has no system, either formal or informal, for offering the help to its own members which it daily offers to patients.

The profession's first priority should be the care of its own members. This need not be excessively expensive or difficult, as it should be organised and run by volunteers. The Samaritans offer a ready example of how this might be done. Regional BMA offices might, for example, keep an Ansafone which has a tape listing interested GPs, their curriculum vitae, and their bypass telephone numbers. A caller could then contact the doctor of his choice, who would have a list of agencies or psychiatrists whom he could consult. With exchange of information a worthwhile service might emerge. With this system the caller could remain anonymous throughout if that was felt to be desired.

No doubt there are many other possible systems for organising such a service. I wonder if any other doctors have views on this subject.

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Clinical practice and epidemiology

SIR,—How refreshing to read Professor E D Acheson's Adolf Streicher lecture (17 March, p 723). I would particularly like to endorse his comments on the failure of the specialty of community medicine to exploit its interest in the vital field of epidemiology.

As a former trainee in community medicine who received a first-rate postgraduate academic grounding in epidemiology, demography, and statistics, I am only too aware of how disappointing it is to experience the reality of community medicine in the National Health Service, and to be shackled by administration and local politics. As Professor Acheson pointed out, epidemiology is not a sterile subject but is the key to prevention of disease and the promotion of positive health—surely what community medicine ought to be about.

Such was my disenchantment that I moved "sideways" to occupational health. While I feel that, overall, occupational factors play a relatively small part in the aetiology of most significant diseases, I would commend occupational medicine as a possible career for anyone who wishes to develop and use epidemiological skills while retaining an active interest in clinical medicine.

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Difficulty in stopping lithium prophylaxis?

SIR,—The recent report of Dr D G Wilkinson (27 January, p 235) on lithium withdrawal has prompted me to write about a similar experience we had in 1976.

A woman, now aged 46, with a history of recurrent hypomania since 1966, was put on lithium in 1972. She remained well with serum concentrations in the range of 0.5-1.0 mmol (mEq)/l until October 1976, when she and her husband asked for the treatment to be stopped. As she had been stable for almost five years and required no hospital admission we agreed to their request. She was advised to reduce her dose by 300 mg at intervals. Four weeks after she started to reduce lithium she became unwell and was brought into hospital by the husband. On admission she was deluded, confused with short lucid intervals, restless, incoherent, and labile in mood. The clinical picture resembled an acute confusional state, as happened in Dr Wilkinson's patient. She was put back on lithium 900 mg daily and within a few weeks her mental state became normal again. Since then she has been maintained well with serum concentrations in the range of 0.7-0.9 mmol/l.

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"Doctors' orders"

SIR,—The article by Dr D A Ellis and others (17 February, p 456) and letter from Dr J R Oakley and Mrs Patricia M McWeeny (17 March, p 748) continue to interest me enormously. I wonder whether Drs Oakley and McWeeny would be prepared to put their views and comments into something more positive, and produce for all those concerned in primary care the sort of written instructions they would like to see issued when dealing with the 4-year-old child with acute otitis media.

I am sure that every medical practitioner who has given this any thought would be delighted if they could produce instructions or "doctors' orders" which are likely to cover the important and worrying complications that can arise in such a common condition as otitis media.

I hope they will rise to the challenge as befits doctors from such a unit as theirs.

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Keeping down the elephants

SIR,—In the absence of untreated controls the results of Mr J P Pollard and others (17 March, p 707) on antibiotic prophylaxis in total hip replacement can be interpreted completely differently. Since they show that there is no difference in the infection rate in patients following three injections of cephaloridine and other patients treated with flucloxacillin for a fortnight, it could be argued that both drugs are equally ineffective in preventing infection and that any form of antibiotic prophylaxis in this condition is useless.

It rather reminds me of the story about two men going to London in a first class Pullman compartment. The first man was reading the