field in an ovulatory mucus with a spinnbarkeit of more than 6 cm has been shown to have statistically significant correlation with a median sperm count of over 28 million/ml,³ and thus a positive test is of great value itself. However, lesser degrees of positivity and even negative postcoital tests are of value only when they have been repeatedly shown to be so at the time of presumptive ovulation and steps have been taken to confirm the validity of this timing. Only then are negative postcoital tests indicative of abnormality. Single and isolated tests without ancillary information are thus merely indications for further investigations of the infertile couple into the multifactorial factors which are potentially related to their inability to conceive.

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¹ Elstein, M, *Clinics in Obstetrics and Gynaecology*, 1974, 1, 345.

² Moghissi, K S, *Fertility and Sterility*, 1976, 27, 117.

³ Tredway, D R, Buchanan, G C, and Drake, T S, *American Journal of Obstetrics and Gynecology*, 1978, 130, 647.

⁴ Elstein, M, *British Medical Journal*, 1975, 2, 296.

SIR,—When Mr G T Kovacs and others ask, "What is normal?" they do not define what they are trying to measure (1 April, p 818).

I have often found motile sperm in good quality mucus with semen whose sperm density has been as low as a quarter of a million per ml. I have also recovered motile sperm five days after coitus when the semen was normal. Thus I agree that the number of sperm present is not an indication of male fertility, as seems to be implied in their question. If sperm are present and motile, one can deduce that the mucus is probably normal in the absence of pus cells. When sperm are absent in apparently good mucus and the husband is oligospermic the mucus should be tested for invasion against donor sperm—and this will decide whether it is a non-receptive mucus or a poor-quality sperm which is the infertility factor.

If it is realised that mucus reflects the quality of ovulation rather than that of the semen false conclusions as to the factor involved in the infertility will be avoided.

BERNARD SANDLER

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SIR,—In reply to the letter from Mr Haydn Didier (13 May, p 1279) I would like to state that each couple in our study group (1 April, p 818) were requested to abstain from intercourse for a period of 48 h before the test, which, as he rightly points out, should be the case.

G L HENSON

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If I had . . .

SIR,—I read Dr John Scott Price's article on chronic depressive illness (6 May, p 1200) with interest and was pleased to find the subject of leucotomy given a favourable airing.

Psychosurgery has progressed greatly from the radical operations of Freeman and Watts in the 'forties and 'fifties, and the work at Atkinson Morley's Hospital is a fine example.

Here carefully selected patients are considered for limbic leucotomy. This is a low-risk procedure from which very good results are obtained in the treatment of depression, anxiety, and obsessional-compulsive neuroses. I would therefore agree with Dr Price in proposing that, despite the finality of surgery, restricted psychosurgical techniques of this type should be considered in some carefully selected patients for whom no other treatment has been successful. While advocating a place for psychosurgery in the treatment of mental illness, however (at least until such time as more "acceptable" alternative therapy becomes available), I would stress the need for some control and standardisation of procedures. This might be achieved by the establishment of multidisciplinary panels (for example, psychiatrist, neurologist, neurosurgeon, and psychologist) who would be responsible for evaluating the present techniques and to whom prospective candidates for psychosurgery would be referred. This would, it may be hoped, avert the misuse of such procedures and hence quell many of the criticisms levelled against psychosurgery.

Finally, on the point of controlled trials may I draw Dr Price's attention to one such trial undertaken in 1953¹ in which four patients from a series of 24 underwent a control procedure only. The skin incision was made and the bone button removed, but no cerebral lesion was produced. All the patients were returned to the ward in a similar condition and the surgical notes were kept secret from the patients and staff. It was shown that improvement occurred preferentially in those patients who underwent cingulotomy, thus demonstrating an absence of placebo and differential nursing effects. The ethical problems encountered in such deception of patients and their subjection to an unnecessary and potentially hazardous procedure will probably prevent the repetition of such a trial. Thus, although this was a very limited study, its uniqueness may add to the interest in the results obtained.

JANET P DOWNS

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¹ Livingston, K E, *Research Publications, Association for Research in Nervous and Mental Disease*, 1953, 31, 374.

SIR,—Having bilateral small central cataracts, I found Mr Brian Harcourt's article (29 April, p 1121) of particular interest, although I had hoped he would mention the place of mydriatics in helping the patient to cope with life in the months or years before he is to benefit from surgery. My very skilful oculist assures me that I have good corrected vision of the order of 6/9, 6/9 and he is not considering me for surgery. But his tests are carried out in near pitch-dark conditions and bear no relation to the conditions in which I have to live and work—that is, daylight and even sunlight.

Apart from my opacities I have moderate presbyopia and astigmatism (both well corrected); I am 66 and in general practice. For the past two years I have had to conduct my surgery in dim religious light with all curtains drawn so that my colleagues think I am developing into a psychiatrist. I use a hand glass to read the maddening small print in the telephone book and even more maddeningly small print on injection ampoules. I have always to stand with my back to any window and go into a dark corner to read. Additionally, I complain of all the things that Mr Harcourt

finds plague his elderly patients. I fail to recognise my patients in the street and hail strangers with unreasonable familiarity. Once out in the street I pray that the sun will not come out or, if it does, that it will be vertically overhead. I can no longer tie on a fly at the water's edge and any small object I drop is lost for ever.

The great problem is driving. In all lights I have the sun visor fully down and wear dark glasses. Phenylephrine drops BP 10% give me 3½ hours of blessed relief. They take exactly 15 min to act. I ration myself to one instillation a day, or at the most two, and use them before setting out by car to visit or when I cycle over the moors for pleasure. For those 3½ hours my vision is practically normal. I am told my intraocular tension is normal and my eyes seem otherwise healthy. How often and for how long in months and years can I continue to use these mydriatics? They are so effective that I feel that there must be some snag somewhere; and can there be detrimental side effects? I wish to continue working in some capacity, but unless I can enjoy the better vision provided by phenylephrine I remain severely handicapped. There must be many of your readers who are similarly afflicted and many who have found ways of coping. An exchange of views could be very helpful.

E C ATKINSON

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SIR,—In his comprehensive review of the treatment of Hodgkin's disease (20 May, p 1329) Dr R A Wood omits a clinical point of importance in diagnosis—namely, that the enlarged nodes may wax and wane in size over days or weeks. This is especially so in the nodular sclerosing variety and may lead the clinician to conclude that the patient does not have Hodgkin's disease, and the all-important biopsy necessary for diagnosis may be delayed. Even then this must be done by a surgeon who does not take the most accessible node (which may only show reactive hyperplasia) but digs deep and takes a larger node which has a greater chance of showing features that enable the pathologist to make the diagnosis with confidence.

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Prevention of neonatal hepatitis B infection

SIR,—In the interesting report by Dr A Derso and others on "Transmission of HBsAg from mother to infant in four ethnic groups," (15 April, p 949) it is concluded that "giving specific immunoglobulin to babies of [HBsAg-positive] Caucasian mothers is not justified." It ought to be pointed out, however, that this refers to otherwise "healthy" mothers, which was the only category studied.

In babies of Caucasian mothers as well as of other mothers with HBsAg-positive acute hepatitis at delivery and HBsAg-positive mothers on chronic renal dialysis the high risk of becoming a chronic carrier of HBsAg is well documented and justifies the use of hepatitis B prophylaxis. Probably repeated injections of high-dose immune globulin (HBIG) should be given, as illustrated by the following case.

A 20-year-old woman had an attack of HBsAg-positive acute hepatitis in March