not asked for reversal. And Mr Winston's conclusion that it "seems unwise to sterilise women under 30 particularly immediately after pregnancy or if their marriage is in jeopardy" is therefore difficult to justify and has a disconcertingly paternalistic ring. It also implies that the stability or otherwise of a marriage should be a prime concern of obstetricians when women request sterilisation.

But what disturbed me most about Mr Winston's article was his statement that "most women in this survey had been told that termination would not be undertaken without sterilisation." I wonder if this form of ultimatum, which Mr Winston condemns, is likely to increase now this operation is performed under a fee-for-service system?

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Haematuria

SIR,—The helpful article by Mr P J R Boyd on haematuria (13 August, p 445) omitted one harmless cause of this symptom.

In 1963 a healthy 16-year-old boy suddenly and painlessly passed urine with fresh blood intimately intermixed. There were no other symptoms or clinical signs. Microscopy revealed the expected masses of red blood cells and no organisms, but did show also, unexpectedly, masses of the sharp refractile Maltese crosses of oxalate crystals. It seemed possible that these crystals had cut the urinary tract causing bleeding. Retrospective history-taking then revealed that he had, a few hours before, eaten three enormous helpings of red currants. This clinched the diagnosis, to my satisfaction, of haematuria due to oxaluria and the patient was spared all urological investigations. He has had no symptoms in the 14 years since. This supports Mr Boyd's two priorities in his article of (a) an accurate history and (b) a microscope available to the general practitioner.

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Adverse effects of lithium treatment

SIR,—In recent years major tranquillisers have been used singly or combined with lithium in the treatment of primary affective illness and affective disorders in schizophrenia. Cohen and Cohen¹ and Loudon and Waring² have reported toxic neurological reactions to the combined use of lithium and haloperidol and the latter have recommended caution when using haloperidol in doses greater than 40 mg/day with plasma lithium levels in excess of 1 mmol (mEq)/l. In the light of their reports and your leading article (6 August, p 346) I should like to report the following two cases in patients with long psychiatric histories.

A 48-year-old woman with unstable bipolar psychosis was maintained on lithium carbonate 1000 mg, the serum level being steady at 0.9 mmol (mEq)/l. Over a six-week period she received 75 mg flupenthixol decanoate and a few days after the last dose of 20 mg marked Parkinsonism (especially akinesia) developed. The drugs were stopped and nine days later she was symptom-free.

A 41-year-old woman with mild hypomania was given haloperidol 1.5 mg twice daily and 0.75 mg at noon. On the day the haloperidol was started she

noticed tingling in her fingers and later complained of episodes of marked pallor or cyanosis of the fingers. These changes were noticed by nursing staff and the haloperidol was stopped, when she complained of marked retrosternal pain. She was being maintained on lithium carbonate 1200 mg daily and the serum level was 0.5 mmol (mEq)/l. The symptoms disappeared and have not recurred though other major tranquillisers have been prescribed with the lithium. No evidence of disease associated with Raynaud's phenomenon has been detected and the ECG is normal.

The first case suggests that flupenthixol should also be used with caution in patients receiving lithium. The time relationship in the second between the symptoms and the use of haloperidol suggests that more than chance may be behind the phenomenon, though haloperidol normally inhibits vasoconstriction.³ A further trial of haloperidol has not been given on account of the retrosternal pain.

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¹ Cohen, W J, and Cohen, N H, *Journal of the American Medical Association*, 1974, **230**, 1283.
² Loudon, J B, and Waring, H, *Lancet*, 1976, **2**, 1088.
³ Johnstone, M, *Anaesthesia*, 1967, **22**, 3.

Poor-risk prostatectomy

SIR,—Your leading article (6 August, p 347), reviewing the paper by Sach and Marshall¹ contains many points with which urologists would agree. It is perhaps a little too critical for Sach and Marshall themselves to make the point that "direct comparison between series is difficult because of the number of variables involved and the difficulty of being certain that patients have been graded in a similar manner."

Most urologists would agree with the benefits of endoscopic resection, but a large gland does pose some problems, particularly in the unfit subject. You are a little naive when you talk of careful selection and of the benefits of operating "early rather than late." We all have our fair share of geriatric unfit customers and one can sympathise with our Adelaide colleagues that the majority were admitted in acute or chronic retention. Those urological units accepting all emergencies from a closed catchment area and working on a restricted bed allocation, worsened by nursing shortages, are all too conscious of these difficulties.

Sach and Marshall look for other methods to obtain better results and in the context of the grossly unfit patient may I suggest that greater attention be paid in the future to the use of cryosurgery of the prostate? It is always difficult to assess the numbers of patients condemned to a permanent catheter drainage. Certainly I have performed successful cryosurgery with very good functional results on respiratory cripples condemned to years of catheter existence in centres staffed by competent and enthusiastic resectionists, which I agree, to quote your leading article, is a "counsel of despair."

Properly performed and using quite a simple technique² cryosurgery takes only 10–20 min of total theatre time and can be performed under a short general anaesthetic or local intraurethral or regional anaesthesia. Depending on social conditions the patient may be discharged home within 48 h draining through an indwelling catheter. Good and lasting functional results can be obtained after catheter removal a few weeks later.

I have preferred to use probes using liquid nitrogen and currently we have no experience of lower temperatures with the nitrous oxide probe advocated by Wright.³

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¹ Sach, R, and Marshall, V R, *British Journal of Surgery*, 1977, **64**, 210.
² Green, N A, *Annals of the Royal College of Surgeons of England*, 1977, **59**, 288.

³ Wright, B, *British Journal of Urology*, 1976, **48**, 203.

Occupational scabies

SIR,—Drs R J G Rycroft and C D Calnan (30 July, p 303) emphasise the importance of overcrowding on board ship as an important factor in the spread of scabies rather than the sexual transmission so frequently favoured. It may not be widely known that a perfect control experiment occurred in 1945 to refute the opinion given during the war by the Advisory Committee on Scabies of the Ministry of Health that "the disinfection of clothing and blankets may reasonably be dispensed with."¹

The Third Infantry Division was transferred from Belgium to Egypt after the cessation of hostilities in Europe, half by air and half by sea. Among those arriving by ship after some three weeks large numbers had severe scabies, while none of the airborne troops were affected. Any "fraternising" in Germany and Belgium would have been equally enjoyed by both groups. The seaborne group, however, had slept in very dirty blankets which had previously been used by German prisoners of war, among whom we had seen many cases of severe crusted scabies.

This outbreak fits very well with the susceptible 15–30 age group, the epidemic which ended in 1949, and the overcrowding on board ship mentioned by Drs Rycroft and Calnan. Perhaps we should think of scabies less readily as a venereal condition and more often as a possible occupational disease.

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¹ Mellanby, K, *Scabies*, Oxford War Manual, pp 42 and 50. London, Oxford University Press, 1943.

Liver tumours and the pill

SIR,—In your leading article on this subject (6 August, p 345) you state that hepatic artery ligation will help to control bleeding, a complication of these tumours, and that "in at least one instance arterial ligation led to necrosis of the tumour."¹ In 1974 my colleagues and I reported that hepatic artery ligation combined with portal vein ligation resulted in the immediate shrinkage of a large, unresectable, vascular tumour, enlargement of which may have been due to prolonged oestrogen administration, and permitted complete removal of the tumour.²

Secondly, as you point out, ultrasonography may be useful to diagnose these tumours² and is an established method of diagnosing and differentiating solid from cystic lesions in the liver.³ It is available in most centres. Surely any patient who has sufficient reason to undergo a liver biopsy should now have the benefit of ultrasound, instead of "liver scan first,"⁴ to warn of the presence of cystic or vascular lesions or dilated bile ducts, which are likely to result in morbid complications after