personal letter.² Another study found that the response rate to a questionnaire was significantly higher when the covering letter was written by the patient's general practitioner than when it was written by a doctor in a research unit.³ It seems sensible to devote attention to the covering letter, making it personal and attractive and stating the purposes and sponsorship of the study and why the respondent's views are particularly sought. Clear instructions and examples should be given, and a statement about confidentiality should be included.⁴

Cartwright has written of the problems of writing about the design of questionnaires without stating the obvious,⁵ yet poorly designed questionnaires are common, create irritation, and waste resources. Departmental audit of questionnaires can be educational and can be used to set standards and devise a quick checklist against which new questionnaires can be compared and audited.

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Inform responders of your results

EDITOR,—On the basis of our practical experience we would suggest two additions to D H Stone's guide to designing questionnaires.¹ Firstly, offer to supply the results of the study to respondents. Having filled in questionnaires on many interesting topics, we have been disappointed not to see the results if, for example, they are not published. Providing a copy of the results is not only courteous but would, we suspect, increase response rates. Secondly, think about anonymity. Respondents should be told what degree of anonymity is being offered as this may colour responses; it should then be mentioned in any published report.

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Prophylaxis with anti-D immunoglobulin

EDITOR,—D Lee, writing on behalf of the National Blood Transfusion Service's Immunoglobulin Working Party,¹ advocates the continued use of a standard dose of 500 IU anti-D immunoglobulin for postnatal prophylaxis in Rh D negative women who give birth to Rh D positive babies so long as this is combined with routine use of the Kleihauer test to detect patients for whom this dose is insufficient.² This supposes that the Kleihauer test accurately measures the size of any transplacental haemorrhage.

In a recent survey among transfusion departments in hospitals in the Yorkshire region we found that methods of performing the Kleihauer test and interpreting the results varied considerably among laboratories: one laboratory may issue up to four times the amount of anti-D immunoglobulin as another on seeing the same number of fetal cells in the test. This confusion probably

arises because of variations in published interpretations of the original Kleihauer method.^{3,4}

For optimal use of anti-D immunoglobulin as postnatal prophylaxis the use of the Kleihauer test should be standardised. If this can be achieved the introduction of a national quality control scheme will be of value.

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Management of acute symptomatic hyponatraemia

EDITOR,—During transurethral resection of the prostate intravascular absorption of urological irrigation fluid (1.5% glycine) may reduce the serum sodium concentration to <115 mmol/l in under 15 minutes (a reduction of more than 80 mmol/l/h), and patients may need inotropic support or ventilation, or both (transurethral resection syndrome). Alan Arieff has suggested that such hyponatraemia should be corrected at rates of only 1-2 (SD 1.7) mmol/l/h,¹ even though he has stated that "the rate of correction is not a factor in the genesis of hyponatraemic brain injury." These rates of correction would allow hyponatraemia after transurethral resection of prostate to persist for hours. Robinson and Ravalia suggested rapid correction of such hyponatraemia with 30% sodium chloride solution²—as used by Worthley and Thomas for hyponatraemic seizures.⁴ We have recently had three cases in which this was done (table).

When the transurethral resection syndrome was suspected we measured serum sodium concentration with a blood gas analyser (type IL1400), introduced an internal jugular line, infused 20 g mannitol for diuresis, and gave 20 ml of 30% sodium chloride solution for 5-10 minutes via the internal jugular line. We remeasured serum sodium concentration, infused a further 10 ml 30%

sodium chloride, and checked that the sodium concentration was above 125 mmol/l. In such cases patients typically present near the end of surgery with confusion and hypotension that is resistant to fluids. Diagnosis is often delayed, and patients are often seriously ill for one or two days during correction of the hyponatraemia. The worst of our three cases was managed without inotropic drugs or ventilation and was relatively mild.

We conclude that the syndrome was corrected by bringing the serum sodium concentration above 125 mmol/l and normalisation of sodium concentration was unnecessary. Correction over five minutes was not associated with any neurological damage and the fast recovery seen after fast correction of the sodium concentration alone suggests that glycine metabolites such as ammonia do not materially contribute to the development of the syndrome. In two of our cases speedy correction obviated the need for intensive care, and the patients went straight to the surgical ward (the third was hyponatraemic for longer and recovered more slowly). Overcorrection of the sodium concentration was easily avoided by frequent measurement with a sodium electrode.

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Deprivation and health

Deprivation contributes to chronic illness

EDITOR,—Margaret Eames and colleagues report that social deprivation and premature mortality are strongly linked.¹ We recently examined the relation between deprivation and the prevalence of limiting longstanding illness (standardised for age and sex) among 0-64 year olds for electoral wards in Worcester and District Health Authority. We used

Details of three cases of hyponatraemia after transurethral resection of prostate

Case No	Age of patient (years)	American Society of Anesthesiologists grade	Presentation	Serum sodium (mmol/l)			Outcome
				Minimum	After first bolus*	After second bolus*	
1	74	II†	Postoperative abdominal pain; confusion; blood pressure fell from 170/100 to 90/60 mm Hg; sweaty and pale	112	123	128	30 Min after infusions felt well; 60 min after looked well and pink; blood pressure 160/100 mm Hg, cooperative; discharged to surgical ward at 2 h and home at normal time
2	74	I	Intraoperative confusion and nausea; breath ethanol rose from <10 to 45‡	115	124	129	10 Min after end of infusions lucid and well; discharged to ward and home as above
3	69	I	Sweaty and unwell at end of operation; blood pressure fell; diagnosis of possible myocardial infarction; managed with analgesia, oxygen, ECG (no change) and enzymes (no rise); at 2 h blood pressure fell to 85 mm Hg systolic in spite of intravenous fluids	114	124	§	After first bolus blood pressure rose to 130 mm Hg systolic; 10ml bolus given; remained unwell and confused; sent to intensive therapy unit overnight and ward in morning; discharged home at normal time

*First bolus of 20 ml, second bolus of 30 ml 30% sodium chloride solution.

†Grade II because of controlled asymptomatic hypertension.

‡Irrigation fluid 1.5% glycine and 1% ethanol to allow monitoring of absorption of fluid with breath alcometer.⁵

§Value lost.

ECG=electrocardiography.