the presence of antisperm antibodies by the gelatin agglutination test² and the tray agglutination test.³

Fourteen women have completed one treatment cycle, with two women having repeat treatment cycles after six months. One singleton pregnancy has been achieved, which resulted in the delivery of a live male infant weighing 623 g at 28 weeks' gestation.

In all 16 treatment cycles the women had no serum agglutinating activity detected by the gelatin agglutination test before or after direct intraperitoneal insemination. Two women, however, had weak agglutinating activity in serum before direct intraperitoneal insemination when tested by the tray agglutination test (both 1:4, head-head agglutination). One of these women showed no change in the measured titre after direct intraperitoneal insemination, and the other had a slight increase in titre on days 14 and 28 after direct intraperitoneal insemination (1:8, head-head agglutination). The two women with repeat cycles had not developed any agglutinating activity detectable by either test during the six months between the first and second treatment cycles.

It thus appears from these preliminary data that, with the numbers of sperm described here, direct intraperitoneal insemination does not induce the production of antisperm antibodies to any appreciable degree over the period studied. A larger study, however, with a longer follow up time is required to confirm this finding.

Z I Z IBRAHIM
B LOWE
P L MATSON
B A LIEBERMAN

Regional IVF Unit,
St Mary's Hospital,
Manchester M13 0JH

M R HAENEY
S E FARRAND

Department of Immunology,
Hope Hospital,
Salford M6 8HD

- 1 Forrler A, Dellenbach P, Nisand I, *et al.* Direct intraperitoneal insemination in unexplained and cervical infertility. *Lancet* 1986;ii:916-7.
- 2 Kibrick S, Belding DL, Merrill B. Methods for the detection of antibodies against mammalian spermatozoa. II. A gelatin agglutination test. *Fertil Steril* 1952;3:430-8.
- 3 Friberg J. A simple and sensitive micro-method for demonstration of agglutinating activity in serum from infertile men and women. *Acta Obstet Gynecol Scand (Suppl)* 1974;36:21-9.

Career counselling for general practitioners

SIR,—The recommendation of the General Medical Services Committee (27 February, p 654) that counselling on careers in general practice should be offered to all junior doctors and medical students is welcome. Vocational training course organisers have in fact been offering such counselling for many years. It is one of the many tasks¹ we undertake that were not envisaged when the current "temporary arrangements" for course organisers' remuneration were made some 15 years ago.

The suggestion that such counselling should not be carried out by those with responsibility for appointments to vocational training schemes is, however, offensive. It implies that course organisers have been unprofessional in their approach to career counselling and have put the interests of their training schemes before those of the doctors they are counselling. I should be interested to know the evidence for such an assertion. In fact, course organisers are uniquely well placed to undertake this counselling. We know the vocational training regulations; are conversant with the knowledge, skills, and attitudes needed for a career in general practice; and have experience in assessing trainees' strengths and weaknesses. Furthermore, we are best able to judge whether our particular

scheme offers the most appropriate training programme for a particular individual, and if it does not we can offer guidance on the type of scheme to which the young doctor should apply.

The GMSC was mandated by the 1985 conference of local medical committees to secure a substantial increase in the remuneration of course organisers. While we appreciate the efforts of the negotiators, they have so far produced no tangible results. The Association of Course Organisers views with concern the implication in your report that the GMSC is now giving greater priority to funding others to perform part of our work than it is to securing course organisers the level of remuneration we have long deserved.

PAUL SACKIN

Association of Course Organisers,
Alconbury,
Huntingdon PE17 5EQ

- 1 Association of Course Organisers. Outline job description for a course organiser in vocational training. *Journal of the Association of Course Organisers* 1985;1:25-7.

Solving the problem of longitude

SIR,—Surely Dr Richard Smith (13 February, p 484) is wrong when he writes that it was the Royal Society that tried to deny Harrison the Longitude Prize.

The £20 000 prize was offered by act of parliament in 1714. Harrison heard of it in 1725, when he was 32. After five years' work he convinced the Astronomer Royal (Halley) that he was on the right track. In the 24 years between 1736 and 1760, backed by the constant help of the Royal Society, Harrison received from the commissioners of the Board of Longitude a total of £3250 towards the cost of developing his chronometer. The society awarded him its Copley Medal in 1749. In 1764, on a voyage to Barbados, the chronometer achieved a degree of accuracy three times better than that demanded by the act of 1714. To authorise payment, however, a fresh act was necessary, and this, shockingly, imposed a new condition—namely that two further chronometers must be made and proved before the £20 000 could be won. So he got only £10 000. Aged 73, with failing eyesight and health, Harrison was unable to deliver another chronometer until he was 80. Clearly a third chronometer was beyond him. Appeals to the King and the Prime Minister, and a petition to parliament, yielded a "bounty" of £8 750. He never received the full £20 000.¹

Thus Harrison's shabby treatment was not at the hands of a scientific society but at those of the government of the day.

CHARLES G PHILLIPS

Horton-cum-Studley,
Oxford OX9 1BU

- 1 Quill H. John Harrison, Copley Medallist, and the £20 000 longitude prize. *Notes and Records of the Royal Society* 1963; 18:146-60.

Points

Should the pill be stopped preoperatively?

Dr RD EASTHAM (Department of Pathology, Frenchay Hospital, Bristol BS16 1LE) writes: Professor L E Hughes and Mr H Sue-Ling state that "drug prophylaxis for deep vein thrombosis inevitably carries morbidity" (13 February, p 447). They do not need to be so gloomy. Poller *et al* have shown that preoperative and postoperative minidose warfarin at a daily dose of 1 mg effectively reduces the incidence of thrombosis after major abdominal or vaginal surgery without causing unfortunate side effects.¹ There is only a slight increase in the prothrombin time and no postoperative

increase in the activated partial thromboplastin time or disturbance of normal haemostasis during the operation.

- 1 Poller L, McKernan A, Thomson JM, Elstein M, Hirsch PJ, Jones JB. Fixed minidose warfarin: a new approach to prophylaxis against venous thrombosis after major surgery. *Br Med J* 1987;295:1309-12.

HIV, genital ulceration, and granuloma inguinale

Dr NIGEL O'FARRELL (King Edward VIII Hospital, Durban, South Africa) writes: Dr D Mabey and colleagues (9 January, p 83) found an increased prevalence of HIV 2 among patients with genital ulcers and suggest a common behavioural factor that predisposes to infection. Their suggestion of prostitution has been made for HIV transmission previously,¹ but more specific risk factors applying to the heterosexual population need to be identified. Prostitutes are often implicated in the transmission of chancroid and syphilis, but other causes of prolonged or recurrent ulceration involving mucosal discontinuity need to be evaluated, in particular herpes, erosive balanitis, and granuloma inguinale. The diagnosis of granuloma inguinale may have been overlooked or underestimated in parts of Africa, as it has been elsewhere.² At the sexually transmitted disease clinic of this hospital we found 28 cases in one month compared with 25 in the whole of 1985. Slides were prepared by the May-Grünwald-Giemsa method, but we subsequently found that in more obvious cases a fast bedside diagnosis could be made using the RapiDiff stain. Most lesions were found to bleed easily and to require two to four weeks of treatment before complete healing. Non-compliance with treatment is common and probably exacerbated by patients' disappointment at not receiving parenteral therapy. A definitive diagnosis of sexually transmitted disease in repeat attenders with genital ulcers may be helpful in determining cofactors in HIV transmission, particularly in areas where prostitution is illegal and subjects unavailable for study.

- 1 Kreiss JK, Koeh D, Plummer FA, *et al.* AIDS virus in Nairobi prostitutes. *N Engl J Med* 1986;314:414-8.
- 2 Sehgal VN, Prasad AL. A clinical profile of donovanosis in a non-endemic area. *Dermatologica* 1984;168:273-8.

Newly registered elderly patients

Dr PHYLLIS LEMON (Welwyn Garden City, Herts AL8 8QW) writes: I am surprised that Drs Helen Graham and Brian Livesley (30 January, p 340) have not hit on the solution to the problem of the slowness of transfer of medical records that we use in our practice. We send a letter to all newly registered patients pointing out that it may take six months for their old records to be transferred and asking them to contact us if they are on any regular medication or if they have any medical problems we should know about. If they do so we write direct to their former general practitioner asking that the contents of their folder should be sent on to us. The family practitioner committee is perfectly happy as long as the outer envelope goes through the bureaucratic procedure, and we get the records. In the case of elderly patients we frequently write to the previous general practitioner without waiting for the patient to contact us.

Negative results at cervical biopsy directed by colposcopy

Dr FABIO PARAZZINI (Istituto di Ricerche Farmacologiche "Mario Negri," 20157 Milan, Italy) writes: Mr Paul Byrne and others (16 January, p 172) found that out of 132 women with persistent cytological abnormalities of the cervix in whom an initial punch biopsy directed by colposcopy gave a negative result 55 (42%) had a cervical lesion on repeated biopsy. They concluded that women with persistent abnormal smears should be carefully followed up despite the negative results of initial biopsy. We think that a single abnormal smear warrants a careful evaluation. We had the opportunity to perform a second smear