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MEDICAL PRACTICE

NEWS AND NOTES

SUPPLEMENT

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CORRESPONDENCE

Because we receive many more letters than we have room to publish we may shorten those that we do publish to allow readers as wide a selection as possible. In particular, when we receive several letters on the same topic we reserve the right to abridge individual letters. Our usual policy is to reserve our correspondence columns for letters commenting on issues discussed recently (within six weeks) in the BMJ.

Letters critical of a paper may be sent to the authors of the paper so that their reply may appear in the same issue. We may also forward letters that we decide not to publish to the authors of the paper on which they comment.

Letters should not exceed 400 words and should be typed double spaced and signed by all authors, who should include their main degree.

HTLV-III infection in spouses of haemophiliacs

SIR,—Dr Peter Jones and colleagues (14 September, p 695) rightly emphasise the urgency of finding the real (versus perceived) risk to wives of male haemophiliacs with human T cell lymphotropic virus type III infection.

May I suggest that we need to study how many female partners who contract infection have practiced anal intercourse? It is known that receptive (but not insertive) anal intercourse is a main risk factor for HTLV-III infection in male homosexuals.[1] Only limited reports have been made of spread to female sexual contacts of patients with the acquired immune deficiency syndrome and of persons in high risk groups; and in the USA the proportion of women affected has remained constant at about 6% of the total.[2] If it were shown that vaginal intercourse was much safer than anal intercourse in the partners of male haemophiliacs, this would greatly relieve anxiety and enable prevention of an important risk factor.

P F UNSWORTH

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1 Goedert JJ, Sarngadharan MG, Biggar RJ, *et al.* Determinants of retrovirus (HTLV-III) antibody and immunodeficiency conditions in homesexual men. *Lancet* 1984;ii:711-6. Quoted in *Acquired immune deficiency syndrome: General Information for Doctors.* London: DHSS, 1985:13.

2 Department of Health and Social Security. *Acquired immune deficiency syndrome: general information for doctors.* London: DHSS, 1985.

Absorption of 1·5% glycine after percutaneous ultrasonic lithotripsy for renal stone disease

SIR,—Because our urology department is actively concerned in the further investigation of the water intoxication syndrome (associated with both transurethral prostatectomies and percutaneous stone surgery) it was interesting to read the paper by Dr John F Sinclair and colleagues (14 September, p 691). There are, however, certain incongruities in the case they report.

Firstly, the use of the term transurethral resection reaction to describe the sequence of symptoms and signs in this case is probably a little misleading. The cause of water intoxication during percutaneous surgery is related to irrigant extravasation rather than the intravenous absorption occurring through the prostatic plexus (although extravasation can occur to an appreciable extent during transurethral prostatectomies). The intravenous form of absorption is much more dangerous from the point of view of the rapidity with which it can occur, although extravasation into the peritoneal cavity may in itself lead to vascular collapse.[1]

Secondly, the report refers to hyperkalaemia being a cardinal feature of the transurethral resection reaction. We, however, have not found this to be the case and as far as we are aware there is only one other report of 1·5% glycine absorption being associated with hyperkalaemia (5·5 mmol).[2] Indeed, hypokalaemia during the ensuing diuresis is the more common feature. Furthermore, to explain the hyperkalaemia on the basis of intravascular haemolysis is certainly contentious: 1·5% glycine is hypotonic, but Nesbit in his original work used 1% glycine in 200 cases with no evidence of haemolysis,[3] nor has this phenomenon been documented elsewhere to our knowledge.

Thirdly, the routine, use of hypertonic saline for the treatment of water intoxication is potentially hazardous due to the risk of precipitating fatal pulmonary oedema.[4] This is normally therefore reserved for combating the serious effects of water intoxication on the central nervous system and the hypervolaemia corrected using loop diuretics, or even allowing the natural diuresis to ensue.[5] There has in fact been only one recent trial on the efficacy of loop diuretics in the transurethral resection reaction, when no difference was found between the treated and untreated groups after 24 hours.[6] Therefore it is difficult to define an appropriate treatment for water intoxication.

Lastly, the paper suggests the use of saline for irrigation during lithotripsy. This proposal must be qualified to exclude electrohydraulic lithotripsy, where use of an electrolytic irrigant is absolutely contraindicated. Since this is becoming the more accepted means of stone disintegration during percutaneous surgery it would appear that the early recognition of irrigant absorption-extravasation and the abandonment of the procedure is the best recourse.

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