temperature for 14 days following activation.[3] With the recently introduced alkaline glutaraldehyde formulations developments in activation techniques, using modified initial pH and buffer systems, have considerably reduced the extent of glutaraldehyde polymerisation after activation. This greatly diminishes the hazard of inactivation from in-use dilution with water carry-over during sterilisation and disinfection cycles.

It is recognised that in-use dilution and inactivation, rather than chemical instability, are now the major factors limiting the use life of many of the recently introduced alkaline glutaraldehyde preparations.[3] Although certain manufacturers recommend a 28-day life in situations of low dilution and low-to-moderate throughput, authorities in cross-infection control in the United Kingdom have questioned the desirability of repeated use of disinfectant solutions. Despite improved chemical stability they are reluctant to recommend repeated use of a solution for more than 7-14 days.[4]

Freedom from corrosivity has always been a desirable feature of a glutaraldehyde-based steriliser and disinfectant formulation, and is a more essential prerequisite with the increasing application to decontamination, where the solution is confronted with a wide variety of metals in equipment.[5]

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[1] Boucher, R M G, *American Journal of Hospital Pharmacy*, 1974, **31**, 546.
[2] Rasmussen, K E, and Albrechtsen, J, *Histochemistry*, 1974, **38**, 19.
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[4] Ayliffe, G, Collins, B J, and Babb, J R, *British Medical Journal*, 1979, **1**, 1019.
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Health visitors and community midwives

SIR,—I should like to comment on the opening sentence of the review of *The Specialised Health Visitor for the Handicapped Baby, Young Child and School Child* (18 August, p 437)—namely, "The health visitor is the only person with an implicit obligation to visit the home of every newborn baby—thus she is in the best position to advise and support parents of handicapped children."

It is true that one of the duties of the health visitor is to make a visit to the home of every baby on or after the 11th day of life. There is, however, no legal requirement in this, nor is there any requirement on the part of the parents of the child to allow access to the baby.

The community midwife is in a very different position, in that she has a legal obligation to make daily visits to the newborn baby and his or her mother for a minimum of 10 days and a maximum of 28 days. More health districts are now requiring the community midwives to make these postnatal visits for the full 28 days. Where this is so, the health visitors' visits may overlap with those of the midwives, or they may defer the initial visit until after the 28th day.

It would appear that, should all mothers and babies have the midwife's continued care and supervision for the first 28 days following delivery, the health visitor would be available to provide the extra advice and support required by those families with special problems associated with the handicapped child.

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The oesophageal airway

SIR,—Dr M G Harries in his excellent article (18 August, p 426) says that nobody in Britain has been trained in the use of the pharyngeal airway invented by Dr Don Michael.

In Brighton, cardiac ambulancemen are in their second year of using the oesophageal airway ("EOA") with great success. These cardiac men, who are also qualified to intubate the trachea, are free to use the EOA if they prefer, when they have been trained to do so. Of the last 100 intubations in Brighton, about 35% have been with the oesophageal airway—so far, fortunately, without complications.

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Genetic association with bladder cancer

SIR,—In a recent leading article (1 September, p 514) you refer to a paper published by myself and my collaborators on the putative role which intrinsic variability might play in the pathogenesis of transitional cell carcinoma of the bladder.[1] You rightly drew attention to some of the difficulties inherent in such studies but made no mention of perhaps a more fundamental inconsistency. If there is a measurable genetic association with bladder cancer, as postulated in our paper, then more than one susceptible person should occur in some families and in turn more than one clinical case is likely. However, a search of the world literature revealed very few reports of such familial cases.[1] If our postulates were correct, familial bladder cancer should not be uncommon.

I am now able to report some preliminary results from a case-control study currently taking place in Yorkshire. Each of 1261 individuals, patients with bladder cancer together with age- and sex-matched controls, was asked about other cases of bladder cancer in first- or second-degree blood relatives. Overall 84 (7·6%) gave evidence that one or more family members also had the disease. Case-control analyses of these data by the method of Mantel and Haenszel[2] give an estimate of the odds ratio of the risk of familial bladder cancer of 1·345. This result is not statistically significant and shows that cases of bladder cancer are only slightly more frequent in the families of the cases.

These preliminary results show that a family history in cases of bladder cancer is not uncommon, and that this type of family history occurs also in the general population. It might have been expected that a stronger family history in the cases would support our genetic findings. This need not be the case if the genes in question are common, as we have suggested. My interpretation would be that certain quite common genes confer susceptibility to the disease but that only a fraction of such people ever get bladder cancer owing to their varying environmental exposures. Possibly the controls with a positive family history have the genes we described[1] and are at a greater risk of bladder cancer. More analyses are required on the existing data, in particular to examine the genetics of the control group with a positive family history; but also a careful follow-up of both the controls and the families of the cases will be essential to see if the prediction about their susceptibility is true.

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Photographing slides during scientific presentations

SIR,—At several conferences that I have recently attended I have been somewhat disturbed, both as a delegate and as a speaker, by the presence in the audience of other delegates photographing slides as they are being presented. I am uncertain of the legal or ethical principles involved, but feel that the practice at least constitutes gross impoliteness since generally no prior permission of speaker or chairman has been sought.

As a relative newcomer to the world of scientific presentations I am loth to interfere with the rules of the game. However, since I feel that this is also a relatively new practice, and one which will ultimately lead to devaluation of the forum good conferences provide, might I appeal to organisers and chairmen to make an appropriate ruling and to publicise and enforce it?

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Treatment of reactions to hymenoptera stings

SIR,—Your experts advising on the prompt treatment of bee and wasp stings (17 March, p 726; 19 May, p 1334) recommend among other things the injection of 1/1000 adrenaline solution. This is not really very practical. When one is away from home it is cumbersome to carry on one's person, at all times during the season, the paraphernalia for injection treatment on the off-chance of being stung. The drawing up and injection by someone unaccustomed to this procedure, in what are likely to be inconvenient circumstances, probably out of doors, possibly with dirty hands (for example, when gardening), are bound to be difficult and fraught with the possibility of delay and error. Your first expert also suggests using a salbutamol aerosol, which is certainly handier in an emergency for the airways obstruction which causes 80% of deaths. This affords little protection for those who react to a sting with anaphylactic shock. Dr M A Ganderton (5 May, p 1216) recommends the inhalation of an adrenaline aerosol (Medihaler-Epi) in the belief that absorption would deal with general manifestations in addition to local relief of bronchospasm. How much would be absorbed by this route is questionable. Not all hymenoptera-sensitive patients are asthmatic, and those unaccustomed to the use of pressurised aerosols might experience difficulty in timing the discharge during inhalation—it needs practice.