can be made to give a positive result by making it alkaline.

Our study shows that even carried out in ideal laboratory conditions the Twentisec test is too inaccurate to be used in its present form even as a screening test. Since we completed our study and from knowledge of the results the manufacturers have been advised to withdraw Twentisec test kits from the market.[1]

We wish to acknowledge the co-operation of Mr. S. Gee and Global Laboratories (Universal) Ltd., who generously supplied the Twentisec test kits used in the study, and to thank the nursing staff of the antenatal clinic at University College Hospital Obstetric Hospital for their help in organizing the survey. We are also grateful to Dr. Joan Stokes for advice and encouragement.

—We are, etc.,

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A. W. CREMER

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1 Winstanley, M., *World Medicine*, 1971, **7**, 9.

Neonatal Meningococcal Conjunctivitis

SIR,—Severe purulent conjunctivitis in newborn infants (ophthalmia neonatorum) is usually caused by TRIC agent[1 2] or by *Neisseria gonorrhoeae*.[3 4] However, thorough bacteriological examination of such cases is important, as the following report indicates.

A healthy baby, whose mother was Greek, developed severe conjunctivitis on 25 May 1970 at the age of five days. The conjunctivitis affected the right eye, which showed lid oedema, purulent exudate, and chemosis. Culture of pus yielded an abundant growth of *Neisseria meningitidis* in pure culture. Conjunctival smears stained with Giemsa revealed abundant neutrophils and intracellular diplococci; TRIS agent inclusion bodies within epithelial cells were not detected. The meningococcus fermented glucose and maltose but not sucrose. Agglutination tests with meningococcal group C sera (Burroughs Wellcome, Commonwealth Serum Laboratories) yielded positive results. When tested by the disc diffusion method on heated blood agar, the meningococcus was sensitive to sulphadiazine (25 micrograms (μg) per disc), sulphadimidine (25 μg), sulphamethoxazole (25 μg), penicillin (0·6 μg = 1 unit), ampicillin (2 μg), tetracycline (10 μg), chloramphenicol (10 μg), and erythromycin (2 μg). By the plate titration method, using horse blood agar and Mueller-Hinton medium with 5% horse serum, respectively, the minimal inhibitory concentration of penicillin G was 0·05 μg per ml (= 0·08 units per ml) and of sulphadiazine 0·2 μg per ml (0·02 mg per 100 ml).

The conjunctivitis was treated by the instillation of chloramphenicol drops and this resulted in clinical improvement and bacteriological cure. However, on the following day, 26 May, the infant showed mucopurulent nasal discharge, and culture of this exudate yielded abundant growth of a meningococcus, also sensitive to penicillin and other antibiotics. Oral penicillin was consequently administered.

The source of infection was not established in this case. It was considered that infection probably originated from a meningococcal carrier, either the baby's mother or a member of the attendant hospital staff. Because of suspected endometritis the mother had been treated with ampicillin after delivery; culture of cervical and urethral swabs collected subsequently failed to yield neisseria.

As the work of C. Brons[5] and R. D. Stuart[6] showed, meningococcal conjunctivitis occurs in infancy and childhood and may readily be confused with gonococcal infection, as such cases cannot be distinguished clinically. Unless cultures are made and the identity of the isolate established, a false diagnosis of gonococcal conjunctivitis may be made. An unusual feature of the present case was the early age of onset, as we know of no fully documented report of meningococcal conjunctivitis in the first four weeks of life.—I am, etc.,

D. HANSMAN

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1 Watson, P. G., and Gairdner, D., *British Medical Journal*, 1968, **3**, 527.
2 Hansman, D., *Medical Journal of Australia*, 1969, **1**, 151.
3 Smith, J. A., *Scottish Medical Journal*, 1969, **14**, 272.
4 *Lancet*, 1969, **2**, 630.
5 Brons, C., *Zentralblatt für Bakteriologie* 1909, **48**, 141.
6 Stuart, R. D., and McWalter, D., *Lancet*, 1948, **1**, 246.

Obesity

SIR,—The article on obesity (26 February, p. 560) added little if anything to the armamentarium of the average general practitioner, and contained two unfortunate statements. Most general practitioners would not agree that there are more young men than women who are significantly overweight, and in the freshmen at this University the ratio of overweight men to women is 1:3.

The inclusion of apples in the list of otherwise recognized fattening foods (for example bread and potatoes) in the sentence on 100 kcal sources may make the unsuspecting wonder whether fresh fruit may freely be allowed to those on a reducing diet after all. It would have to be a truly enormous eating apple to supply this number of calories—500 g or more. Life is hard enough for the slimmer (and her doctor) without implying that she can't eat freely of fresh fruit.

Since obesity is such an important and frequent problem—one in ten of the freshmen here are significantly overweight—it is important that its management is correctly based.—I am, etc.,

T. C. DANN

University of Warwick

SIR,—In his article on "Obesity" Dr. John Anderson (26 February, p. 560) advises weighing once a week or a fortnight. In premenopausal women mid-cycle weights are usually preferable. This minimizes misleading—and sometimes discouraging—results due to cyclical fluid retention.—I am, etc.,

JEFFREY SEGALL

London N.W.2

Disodium Cromoglycate in Young Children

SIR,—We have been surprised to find in current literature[1] and be told repeatedly by doctors inside and outside hospital that asthmatic children under the age of 6 or 7 years are rarely able to co-operate in inhaling disodium cromoglycate (Intal).

Among 200 children with asthma attending a special paediatric clinic in this hospital, 41 began successfully to take Intal before their fifth birthday. Of these, six started treatment before the age of three (youngest aged 2 years 4 months), and 10 others before the age of four.

We believe that failure of the young child to use a Spinhaler is probably due to a lack of detailed explanation and instruction in the working of the apparatus *to both the child and the parent*. These must be supplemented by frequent and continuous encouragement and support.

We feel it is unfortunate that this myth should be perpetuated and thus deny the young asthmatic child a chance to benefit from simple and proven efficient treatment.
—We are, etc.,

S. BEDFORD
J. A. KUZEMKO

Peterborough District Hospital

1 *Disodium Chromoglycate in Allergic Airways Disease*, proceedings of a symposium at the Royal Society of Medicine, ed. J. Pepys and A. W. Frankland. London, Butterworths, 1969.

Gynaecological Illness after Sterilization

SIR,—May I add a cautionary word to your recent correspondence (19 February, p. 504) on the merits of total vaginal hysterectomy as a sterilization procedure? I have within six weeks met two patients who suffered loss of orgasm following this procedure. Both had previously rich sexual lives; both approached surgery confident in assurances that this would be unimpaired. In neither was an unconscious need for the possibility of further pregnancy a relevant factor.

A woman of 51 had vaginal hysterectomy for menorrhagia four years ago. The first post-operative intercourse, eagerly anticipated, was a deep disappointment and shock to her and her husband. It took them two years to relearn a technique satisfactory to them both. The emotional trauma for both was severe; it is unlikely that a less rich and stable relationship would have survived it.

A woman of 47 had the operation for the same reason three years ago, and complained of "frigidity" since. Attempts at intercourse produced no orgasm for 18 months and were abandoned. Great marital stress has resulted. Armed with the knowledge of the preceding patient, I could interpret the anxiety and despair, and recommend a re-educative technique.

Rationally advisable though it may be, the loss of her child-bearing apparatus has always potentially profound psychological implications for a woman. If her fears about loss of femininity are not to become fact, it seems important to elicit pre-operatively how important is cervical and uterine sensation to her sexual performance. Prophylactic re-education may then begin in good time. Her sexual capacity need not be diminished, but the couple are entitled to be warned that their sensation may be different.— I am, etc.,

PRUDENCE TUNNADINE

London W.1

SIR,—Though I have read Professor J. S. Scott's letter (19 February, p. 504) carefully several times I still find his logic questionable and his claims difficult to accept. The thesis that many women who are sterilized are best treated by hysterectomy is now