groups were judged with a scoring system for the cosmetic results by an impartial, blinded surgical observer, and the mean score in each group was the same.

The tissue adhesive in our trial was applied by practice nurses, who were already competent in suturing. They found that its use was easy to learn and it was a preferable option for many wounds. We think that tissue adhesives, when used appropriately (as outlined by Mr Watson and the manufacturers), are ideal for smaller casualty units or general practitioners and would therefore encourage the Department of Health to consider making them prescribable on an FP10 prescription, bearing in mind that they are indeed cheaper than suture materials.

I hope that Mr Watson's study will stimulate a further review of these substances, for which there is a paucity of good published research.

CONOR O'SHEA

Latham House Medical Practice,
Melton Mowbray LE13 1NX

1 Watson DP. Use of cyanoacrylate tissue adhesive for closing facial lacerations in children. *Br Med J* 1989;**299**:1014. (21 October.)

SIR,—Mr David P Watson used glass capillary tubes in the multiple use of phials of cyanoacrylate (Histoacryl) tissue adhesive in facial lacerations.[1] In Cardiff we have developed an alternative technique for the multiple use of phials of cyanoacrylate tissue adhesive. This uses a polyethylene pipette (Alpha Laboratories, LW4231) with a fine stem (25 mm by 1 mm). The tip of the phial of glue is cut 3 mm from its lowest point to allow it to be capped. The stem of the pipette is then dipped into the phial of glue and the requisite amount aspirated. The phial of glue is then capped by a universal Luer lock (Vygon, 9888). The pipettes cost only 3p each and can easily be sterilised. Because the pipette has a soft bulb very good control is achieved when applying glue to wounds. Members of staff are instructed to use a new pipette every time glue is aspirated from the phial. This technique seems to have advantages over the glass capillary method, especially in ease of application.

MICHAEL J McCABE
T HANDEL WALTERS

Cardiff Royal Infirmary,
Cardiff CF2 1SZ

1 Watson DP. Use of cyanoacrylate tissue adhesive for closing facial lacerations in children. *Br Med J* 1989;**299**:1014. (21 October.)

Zidovudine in AIDS dementia complex

SIR,—There are several weaknesses in the paper by Dr Peter Portegies and colleagues on the decline in AIDS dementia complex since the introduction of zidovudine.[1]

The claim that the dementia rate in AIDS patients has decreased is difficult to assess because prevalence rather than incidence was measured and the patients were examined at a variable time after presentation (from a few days up to two years). No information was provided on patterns of contact with the clinic over time—for example, recent cases may have had earlier contact. A study of secular trends in disease pattern is especially difficult to interpret if the diagnostic criteria are changed during its course, as the diagnosis of dementia was here, from DSM-III[2] to AIDS dementia complex.[3]

The validity of the diagnosis of AIDS dementia complex in this study was not established. The complaint of declining memory is quite common in AIDS patients who have no abnormality on neuropsychological testing, so diagnosis by clinical interview alone is unsatisfactory. The nature of the neurological symptoms in the whole sample was not described. Computed tomography and neuropsychological testing were performed in some cases, but the results are not given.

In attributing changes in the clinical picture of their patients to the effects of zidovudine Dr Portegies and colleagues do not consider three important possibilities. Firstly, the apparent change could be an artefact of alterations in diagnosis or case ascertainment. Secondly, there could be a real change but not in dementia—for example, better levels of general wellbeing in more recent patients would result in fewer complaints such as impaired memory or concentration. Thirdly, any change that has occurred could be attributed to treatments other than zidovudine.

The authors use the absence of HIV I p24 antigen in the cerebrospinal fluid of patients treated with zidovudine to support their argument that zidovudine decreased the incidence of AIDS dementia complex. Their earlier study had, however, concluded that HIV I p24 antigen was not a reliable marker of neurological deterioration in AIDS.[4]

We are concerned that the rush to publish articles on AIDS may lead to the relaxing of scientific standards by authors and those who assess articles. We note, for example, that not only are confidence intervals not reported in the paper but no statistical tests are referred to at all in support of p values. Claims about drug treatment in AIDS need to be evaluated with at least the same rigour as other treatment trials so that we do not increase the problems already encountered by researchers attempting to recruit patients to properly randomised and controlled drug trials.

RICHARD MORRISS
ALLAN HOUSE

General Infirmary,
Leeds LS1 3EX

1 Portegies P, de Gans J, Lange JMA, *et al*. Declining incidence of AIDS dementia complex after introduction of zidovudine treatment. *Br Med J* 1989;**299**:819-21. (30 September.)
2 American Psychiatric Association, Committee on Nomenclature and Statistics. *Diagnostic and statistical manual of mental disorders*. 3rd ed. Washington, DC: APA, 1980.
3 Navia BA, Joran BD, Price RW. The AIDS dementia complex. 1: clinical features. *Ann Neurol* 1986;**19**:517-24.
4 Portegies P, Epstein LG, Tjong A, *et al*. Human immunodeficiency virus type 1 antigen in cerebrospinal fluid. Correlation with clinical neurologic status. *Arch Neurol* 1989;**46**:261-4.

Brain stem death and organ donation

SIR,—We agree with many of the points raised by Dr A Bodenham and colleagues.[1] There is little information available concerning the true incidence of brain stem death and the number of cases in which donation is possible. This is, of course, the subject of a national audit of deaths occurring in intensive care units, the results of which should prove most revealing. The local availability of cadaveric organs for transplantation compared with the actual retrieval rates have been examined in Nottingham in 1975 and 1983.[2,3]

We have recently conducted a prospective study of all deaths occurring in the four intensive care units in Nottingham during the first six months of this year. Brain stem death was diagnosed in 27 of 92 patients before cardiopulmonary arrest. Seventeen of these 27 patients were potentially suitable organ donors, but only eight came to organ donation. The reason for non-donation in this and the previous Nottingham studies are shown in the table.

Organ donation in Nottingham

	1975	1983	1989
No of donors	6	6	8
Donation refused by family	3	7	4
Donation not considered by doctors	8	2	1
Total potential donors	17	15	17*
Potential kidneys/million population/year	43	42	68

*Four donors became hypotensive before consent could be sought.

Our data support the suggestion that in few cases of potential donation is consent not requested, and that refusal of consent by the next of kin is now the main obstacle to higher retrieval rates. As happened in Cambridge, several of our potential donors became hypotensive before family consent could be sought, and aggressive support of cardiovascular function may increase the absolute numbers of donors available.

M J S DENNIS
M J RYAN
R W BLAMEY

City Hospital, Nottingham NG5 1PB

1 Bodenham A, Berridge JC, Park GR, Brain stem death and organ donation. *Br Med J* 1989;**299**:1009-10. (21 October.)
2 Dombey SL, Knapp MS. Prospective survey of availability of cadaveric kidneys for transplantation. *Br Med J* 1975;ii:482-3.
3 Smithers BM, Cooksey G, Foster MC, Blamey RW. Availability of organs for transplantation: a three year study. *Br Med J* 1986;**293**:293.

SIR,—We agree with the views of Dr A Bodenham and his colleagues that "required request" for organ donation would not significantly improve the supply.[1] In our unit failure to proceed to donation would be for the same reasons as occur in Cambridge, and these would occur in a similar percentage of suitable donors.

We are more critical of the loss of organs as a result of staff shortages in the major transplant centres. In two of our last three patients in whom permission was obtained for multiple organ donation this did not take place owing to the appropriate "harvesting team" not being available. In one case a heart, a liver, and lungs were lost simply as a result of nursing shortages.

We think that if the effort and resources that are currently being expended in determining the potential effectiveness of "required request" were instead channelled to resolving nursing shortages in transplant centres that a real improvement in organ procurement would occur.

K G LOWRY
G G LAVERY

Robert C Gray Regional Intensive Care Unit,
Royal Victoria Hospital,
Belfast BT12 6BA

1 Bodenham A, Berridge JC, Park GR. Brain stem death and organ donation. *Br Med J* 1989;**299**:1009-10. (21 October.)

Why are operations cancelled?

SIR,—Mr Simon Morrisey and colleagues quote a combined non-attendance and cancellation rate for operations in their ear, nose, and throat unit of 27·4%. We have been auditing our inpatient ear, nose, and throat surgery for the past nine months. Our combined rate of non-attendance and cancellations for this period is only 5·9%. It would seem that patients in Mr Morrisey and others' unit were not required to confirm their availability for operation. In our department we send each patient notification of surgery about one month before the planned date of surgery, and we include information about stopping the contraceptive pill if appropriate to the planned operation. Patients are then expected to confirm that they are available to attend for surgery. We estimate, from the figures provided, that if a similar system of patient notification had been required by Mr Morrisey and his colleagues their non-operation rate would have been almost halved (14%). Patient notification is