

HOT BODY, COLD URINE

To the Editor: In the January 6 issue of the *Journal* (page 23), there is an interesting figure, which purports to show the relation between "oral and freshly voided urinary temperatures." The authors are to be congratulated for a fantastic accomplishment. It is very hard indeed to acquire urinary temperatures of any kind. To have gathered 55 freshly voided urinary temperatures boggles the mind.

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Again we owe a debt of thanks in stopping all such lowly pranks by those who think that they are hot when we suspect that they are not.

Just find the urine temp. too cold,
(by Murray, *et al.*, we are told)
and it will tell the doctors curious
it is, of course, a fever spurious.

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To the Editor: I read with interest the paper by Murray *et al.* (*N Engl J Med* 296:23, 1977) because I also have found an IVAC thermometer useful in the diagnosis of factitious fever. A point not mentioned is whether or not the plastic probe cover was used when the urine temperature was taken. I have found that if this cover is omitted, and the probe alone is used, the IVAC will register the urine temperature much more quickly. This procedure minimizes the external heat loss during temperature recording (as much as 0.5°C). This method seems to have no detrimental effect on the IVAC thermometer.

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The above letters were referred to the authors of the article in question, three of whom offer the following reply:

To the Editor: Dr. Lasagna quite appropriately points out the error in the legend of Figure 1 in our report. For clarity, the word "temperature" should have been inserted after "oral." It would also have been more acceptable to use the term "urine temperature" or "temperature of freshly voided urine" instead of "urinary temperature." We should like, however, to take the second sentence of Dr. Lasagna's letter out of context and accept his congratulations.

We used the recommended disposable plastic probe covers for the IVAC thermometer. The benefits (less heat loss) of using a naked probe as suggested by Dr. Stratton appear to be outweighed by several disadvantages: the patient's and nurses' emotional reaction to using the same probe later for obtaining oral temperatures, the questionable propriety from a hygienic point of view and our lack of enthusiasm for having to take the time to clean the probe thoroughly after each use.

To the Editor: Murray *et al.* demonstrate a technic to aid the diagnosis of factitious fever by simultaneous measurement of oral, rectal and urinary temperature. The nomogram that they have constructed from the data is apparently based on data collected when the environmental temperature has been lower than the temperature of the subjects tested.

There has been more than an occasional summer day during my house officership when the temperature of the air in the hospital room has been higher than the patient's temperature. Thus, the air through which the urine passes and the receptacle that catches the urine may indeed have a temperature higher than the urine.

Therefore, on the occasional summer days when one is attempting to diagnose factitious fever, the temperature of the urine may exceed the body temperature. Thus, the physician may have to consider a urinary fever factitious and void his results.

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Fortunately, we performed our study during the winter and early spring and did not encounter the potential problem outlined by Dr. Goldstein. We heartily sympathize, however, with any patient or house officer, real or factitious, who has to put up with a hospital room where the ambient temperature on any summer day exceeds body temperature.

One of Dr. Kleinman's points is reasonable and deserves reply—that is, it should indeed be impossible to manipulate the reading of an IVAC thermometer held by an attendant, and it is quite possible, therefore, that modern technology will reduce the frequency of factitious fever. Nonetheless, there are ways of factitiously elevating such temperatures. Short of catching a manipulating patient red-handed, measuring the urine temperature in the setting that we described is the only way to be virtually certain of the diagnosis.

Regarding the humble submission of Dr. Salit, we respond as follows:

We thank all our readers ambitious
In response to our research auspicious
That when temperature's hot
And the body is not
The urine says "fever factitious."

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To the Editor: I think the placement of the article, "Urinary Temperature: A clue to early diagnosis of factitious fever," under the Medical Intelligence section is an indiscretion.

I suggest that if one has a battery-operated electronic thermometer, the need for measuring urine temperatures is totally superfluous. Moreover, if one uses more conventional temperature-measuring instruments, the time required to record the measurements allows sufficient cooling of the urine to preclude the usefulness of this clinical assessment.

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To the Editor: With reference to the article by Murray *et al.*, I humbly submit the following:

Axillary, rectal, oral
(Other places are immoral.)
readings can be most capricious
When it comes to temp. factitious.

VASECTOMY REVERSAL

To the Editor: I enjoyed reading the excellent review on reversible male contraceptives by Bremner and de Kretser.¹ I was concerned, however, that their brief section on the reversibility of vasectomy would be misleading to the average reader, who may not be aware of the microsurgical developments that have recently been reported.²⁻⁶ With a perfect microscopic two-layer anastomosis, using six to eight 9-0 or 10-0 interrupted nylon mucosal sutures, 90 per cent of patients, whose vasectomies were performed within 10 years of the reversal operation, achieved fertility within the first year after opera-

ation, and the pregnancy rate was not different from the population norm.

Our work has proved that the majority of cases in which fertility is not achieved after a vasectomy reversal are related to inadequate microscopic suturing, sperm leakage and partial obstruction, caused by sperm granuloma and fibrosis at the suture line. These patients usually can again be restored to fertility with a reattempt at reversal, with use of more meticulous microscopic technic.

The application of microscopic operations, clinically, to problems in fertility, during the last several years, has been just as exciting as the expansion of basic knowledge of the medical aspects of fertility and infertility.

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1. Bremner WJ, de Kretser DM: The prospects for new, reversible male contraceptives. *N Engl J Med* 295:1111-1117, 1976
2. Silber S: Microsurgery in clinical urology. *Urology* 6:150-153, 1975
3. Friend DS, Galle J, Silber S: Fine structure of human sperm, with deferens epithelium, and testicular biopsy specimens at the time of vasectomy reversal. *Anat Rec* 184:584, 1976
4. Silber S: Microscopic technique for reversal of vasectomy. *Surg Gynecol Obstet* 143:630-631, 1976
5. *Idem*: Perfect anatomical reconstruction of vas deferens with a new microscopic surgical technique. *Fertil Steril* 28:72-77, 1977
6. Silber S, Galle J, Friend D: Microscopic vasovasostomy and spermatogenesis. *J Urol* 117:299-302, 1977

The above letter was referred to the authors of the article in question, who offer the following reply:

To the Editor: We were interested in Dr. Silber's letter and the references to his articles, all but one of which were unpublished at the time we compiled our review. The two most recent and apparently most detailed articles have not, even now, reached the antipodes, so we are unable to comment upon them. The description in his letter of a 90 per cent fertility rate within one year after vasectomy repair, however, is very encouraging, and his technic certainly seems worthy of careful evaluation by other surgeons. It is important, of course, that any surgical technic directed to a large population group, as vasectomy repair probably would be, should be successful in the hands of a large number of surgeons, not just a few of the most skilled.

We should also like to point out that the name of Katherine Dexter (Mrs. Stanley) McCormick was misspelled in our article.

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AUTHORSHIP AND INDEXING

To the Editor: One of the most recent articles of interest to information scientists is "Et Al. Gets Nobel Prize" by Frederick Hecht, M.D. (*N Engl J Med* 296:234, 1977). This amusing piece, which observed a constant increase in the number of authors per biomedical paper, has serious implications for indexing services such as *Index Medicus* that attempt to create "literary units" for authors by providing entries for all authors of a paper, rather than only for the first, which would suffice for citation purposes. *Index Medicus* is used primarily for subject access to the literature, but *Science Citation Index* assumes that the author is a major link in the scientific chain of development, and thus an important method following work in a given area is to see whether the paper of the original researcher in that area has been cited.¹ *Science Citation Index* has also attempted to provide added entries for multiple authors, but it is questionable whether it can continue to do so for the increasing number of authors contributing to the world's scientific journals. *Science Citation Index* stresses timeliness of publication rather than bibliographic accuracy, and thus it does not go to the trouble of distinguishing between authors with identical names. In fact, it reduces the full names of authors to initials and interfiles the works of all authors with the same initials. It has been sharply criticized for this procedure

by Seymour Lubetky, the champion of traditional cataloging accuracy.²

At a recent library conference, Hugh Atkinson expressed the opinion that distinction between authors with the same name and collection of literary units for secondary authors were outmoded ideas and irrelevant to scientists.³ He quoted the humanists' view that the works of a great poet should be read in their entirety, but asserted that in scientific work the individual author was unimportant. Thus, he claimed that the only clusters information systems should create are subject-oriented ones. Support for this idea is found in a recent article dealing with redundancy in scientific literature, which found the greatest overlap in articles emanating from the same specialized research institute.⁴

In library cataloging, there is an arbitrary rule that if a work has more than three authors, the first or main element of a citation becomes the title, with possibly only the first author getting a secondary or added entry.⁵ The *New England Journal of Medicine* showed an intuitive recognition of this principle when it relegated the 36 authors of one paper to a footnote, as Strub and Black reported.⁶ Recently, there has been research showing that the whole author main-entry tradition is rooted in Western humanist philosophy, which stresses the individual. In the Eastern tradition, the scholarly work or book has always been more important than its author, to the extent that families were named after their ancestor's most famous work.⁷ I doubt whether this sort of reverse eponym will take hold in biomedicine, since titles of papers have lengthened as much as author statements.

In conclusion, I must admit that I sympathize with Dr. Hecht's nostalgia for the "paper by one person writing grantlessly in the first person singular." I am happy to say that so far, all mine fit that description. In fact, the only nonintellectual assistance that I have ever had to acknowledge is my husband's typing!

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1. Garfield E: Science Citation Index: a new dimension in indexing. *Science* 144:649-654, 1964
2. Lubetky S, Hayes RM: Bibliographic dimensions in information control. *Am Documentation* 20:247-252, 1969
3. Daniels Ganning MK: The catalog: its nature and prospects [summary]. *J Library Automation* 9:48-66, 1976
4. Cleverdon CW, Kidd JS: Redundancy, relevance, and value to the user in the outputs of information retrieval systems. *J Documentation* 32:159-173, 1976
5. Anglo-American Cataloging Rules. Chicago: American Library Association, 1967, p 14
6. Strub RL, Black FW: Multiple authorship. *Lancet* 2:1090-1091, 1976
7. Hamdy MN: The Concept of Main Entry as Represented in the Anglo-American Cataloging Rules. Littleton, Colorado, Libraries Unlimited, 1973, p 20

LET'S IGNORE A BOX FROM PANDORA

To the Editor:

Pandora was a saucy chick
Who laughed at keys and locks
In fact she disobeyed the gods
And opened up the box.

What then ensued has now imbued
The medical profession.
We hardly ever make a speech
Without her intercession.

"A veritable Pandora's box"
How often do we meet it!
Here's one, at least, who'd like to say
For heaven's sake delete it.

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