measure the acid refluxing into the oesophagus is to monitor the intra-oesophageal pH by continuous recording." Such a method is, however, impracticable except in a few patients being studied in a research programme; it is not a routine procedure which can be used readily in a busy radiological department during an upper gastrointestinal examination session.

Various manoeuvres have been devised or employed for the demonstration of a hiatus hernia and/or gastro-oesophageal reflux, but because of the complexity of some of these they are not used except by enthusiasts of a particular technique. None are likely to be used by busy radiologists unless they are simple, and indeed even the head-down (or Trendelenburg) position has been abandoned by some.

I am indebted to Dr. W. R. Eyler of the Henry Ford Hospital, Detroit, (editor of *Radiology*) for drawing my attention to the simple expedient of observing whether reflux occurs when a patient drinks water from a disposable cup via a drinking straw in about a 10-15-degree head-down position and turned to the right 20-30 degrees—a method used previously by de Carvalho and termed by him "test du siphonage."[1] This is simple, takes up very little time, and is not at all unpleasant to the patient, who will almost without exception readily drink a cup of water after having had his barium sulphate. For 10 years I have used this method and commended it to registrars in training. I have always found that the results obtained by this method closely follow symptoms described by the patients. Many who, for example, complain of sore throats and oesophagitis have gross reflux up the throat demonstrated in this way, whereas other manoeuvres show only minor reflux. The same is true for patients with upper oesophageal webs. Hiatus hernias are also readily studied, but as pointed out by many authors these are not necessarily present with reflux or vice versa. These two conditions are also clearly distinguished in de Carvalho's paper. The only essential preliminary point is that the oesophagus should be empty of barium before the water is swallowed. Monitoring of swallowing is readily observed, either by watching (on the T.V. monitor) air bubbles passing down the oesophagus with the water or by looking at the cup. If the water test is carried out as the last part of the stomach and duodenal examination there is no problem arising from dilution of the barium suspension in the stomach, and if a follow-through is to be done the water is helpful in facilitating the transit of barium through the small intestine.—I am, etc.,

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1 de Carvalho, M. M., *Archives des maladies de l'appareil digestif et des maladies de la nutrition*, 1951, **40**, 280.

Epigastric Pain in Duodenal Ulcer

SIR,—In the original Bernstein test pouring 0·1 N hydrochloric acid blindly down a nasogastric tube occasionally produced epigastric as well as retrosternal pain.[1] This observation, combined with the fact that blowing up a balloon in the lower oesophagus could produce abdominal pain,[2] was the basis for my developing the lower oesophageal acid perfusion test for epigastric pain. In the first study[3] the possibility that epigastric pain could arise from the oesophagus was confirmed, but it was not a completely reliable test. A second study,[4] however, showed that if attention was paid to the severity of the symptoms the test was always positive. Nocturnal waking was used as an indication of severity and if the patient had been awoken any time during the previous four weeks he always had a positive epigastric pain reproduction test.

Acid must be perfused through the manometry units so that it enters the lower oesophagus accurately. It is of no use passing a nasogastric tube blindly into the oesophagus after gastro-oesophageal sphincteric pressures have been measured.[5] I emphasize these points again because the study by Dr. J. B. Dilawari and others (3 May, p. 254) has shown that epigastric pain could be produced by pouring acid down the oesophagus but they are unable to make this test reliable. If these workers are still interested in this subject they might like to come and visit the East End of London one day to learn about the small details that make the test reliable.—I am, etc.,

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1 Bernstein, L. M., and Baker, L. A., *Gastroenterology*, 1958, **34**, 760.
2 Pollard, W. S., and Bloomfield, A. L., *Journal of Clinical Investigation*, 1931, **10**, 435.
3 Earlam, R. J., *British Medical Journal*, 1970, **4**, 714.
4 Earlam, R. J., *British Medical Journal*, 1972, **2**, 683.
5 Earlam, R. J., *Clinical Tests of Oesophageal Function*. London, Crosby Lockwood Staples. In press.

Abortion (Amendment) Bill

SIR,—For a journal which is expected to be a voice for the medical profession, the *B.M.J.* goes too far in its condemnation of Mr. James White's Abortion (Amendment) Bill (17 May, p. 352). Let's face it, abortion is a very controversial subject. This applies to doctors as much as to the public at large.

There is a good cross-section of our profession whose views you choose to ignore. These members include gynaecologists and general practitioners disillusioned through their experience of abortion in practice. They do not dream of a Utopia where the Department of Health will provide abortion for social convenience. The basic fact is that abortion destroys life, and any justifiable grounds must therefore be restrictive. Their belief, in a society which abhors totalitarian attitudes, is that doctors should honour the oath of Hippocrates: "I will maintain the utmost respect for human life from the moment of conception."

You attach great importance to the dangers of interfering with a doctor's discretion. The rights of society to demand some control on the practice of abortion are well established through previous Acts in 1803, 1861, and 1929. Though this may not have been the intention of its sponsors, the 1967 Act effectively removed any such control. Since the almost non-existent risk to the life of a healthy woman in an abortion properly performed early on in pregnancy is likely to be less than the present very low, but not wholly negligible, risk in childbirth, it is easy to see how the 1967 Act can be used to justify abortion on demand.

The introduction of an Abortion (Amendment) Bill was probably inevitable given that the shortcomings of the Lane Committee Report,[1] which you quote with apparent approval, have not been debated in Parliament. Even this report acknowledges that abortion "violates the sanctity of life or extinguishes the potentiality of a life" (para. 606). Yet it unanimously recommends that the 1967 Act should not be amended in a restrictive way. The view is that the end justifies the means, involving the taking of a life. This creates a dangerous precedent in modern law.

We shall agree that it is unlikely that all parties can be satisfied whatever the outcome of the present Bill. If the B.M.A. is to make a responsible contribution it must fully represent all shades of medical opinion. This is an opportunity for the *B.M.J.* to act as an open forum so that decisions can be reached following an informed exchange of views.—I am, etc.,

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1 *Report of the Committee on the Working of the Abortion Act*. London, H.M.S.O., 1974.

SIR,—Your leading article (17 May, p. 352) is quite right—the Lane Report[1] *did* state that "most N.H.S. abortions and many in the private sector had been on grounds within the terms of the Act." Which is another way of saying that some N.H.S. abortions and many (? most) in the private sector were *not* done within the terms of the Act. That must surely indicate a disregard for the law which would never be tolerated in any other field and which the Abortion (Amendment) Bill is designed to put right.

You also say that this Bill represents "a serious threat to the professional freedom of doctors. In assessing an individual case the question would no longer be what was best for the patient. . . ." But there are always two patients involved in obstetrical cases, one of them being the baby; and however much precedence may be given to the interests of the mother, treatment should not be prescribed for her taking no account of its effects upon the child. With abortion, of course, the child is sacrificed, which is why any law protecting the interests of the child (that is to say, not permitting abortion simply on demand, which was *not* recommended by the Lane Committee) must necessarily place some limits upon the professional freedom of doctors.

Finally, on the question of the onus of proof. It may be true that placing this upon the accused person in cases involving non-compliance with the regulations is "a denial of the fundamental legal presumption of innocence until guilt has been proved." But it is not an "extraordinary provision," or at any rate not an unprecedented one, since section 4(1) of the present Abortion Act provides that "in any legal proceedings the burden of proof of conscientious objection shall rest on the person claiming to rely on it."—I am, etc.,

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Cambridge

1 *Report of the Committee on the Working of the Abortion Act*. London, H.M.S.O., 1974.