native therapy, the use of a depot LHRH analogue in combination with a drug or drugs to block production or use of peripheral androgens is certainly worth further study.

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Lung biopsy

SIR,—While agreeing with most of the conclusions in Dr John Macfarlane's leading article (12 January, p 97) I should like to make the following observations. Open lung biopsy is a serious trauma, and, although the diagnostic yield is good, it is achieved at the expense of the usual complication rate for thoracotomy, considerable pain and discomfort, and a week or 10 days' stay in hospital. In contrast, percutaneous biopsy is relatively painless and can be done as day procedure, although the patient may need to be kept under observation overnight if a pneumothorax develops. In diffuse lung disease the diagnostic yield from trephine biopsy is comparable with that of open biopsy and the procedure can be repeated if necessary.[1] In my personal series of over 700 trephine biopsies of lung and pleura the diagnostic yield in pulmonary disease has remained about 80%. Frank haemoptysis has been rare at 1% and has ceased spontaneously. Intubation for pneumothorax has been required in only 6% of cases. There has been only one death, in a patient in intensive care who had a cardiac arrest and died two days later. I consider that in diffuse lung disease trephine biopsy is safer and more cost effective than open biopsy.

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1 Steel SJ, Winstanley DP. Trephine biopsy of the lung and pleura. *Thorax* 1969;24:576-84.

New concepts in incontinence

SIR,—The work of Dr M Swash and others supports the view that motor nerve damage is a factor in the pathogenesis of both anorectal incontinence and genuine stress incontinence (5 January, p 4). Is it justified, however, to conclude that "surgical treatment of urinary and faecal incontinence should offer more help" than other therapies? The finding of increased fibre density in anal sphincter musculature suggests that reinnervation of the affected muscles is occurring.[1] This process may explain why most patients with genuine stress incontinence have been reported to respond to a course of pelvic floor exercises.[2 3] This non-invasive, effective treatment has considerable advantages over surgery, with its risk of damage to the nerve supply or puborectalis,[4] and must surely remain the treatment of first choice in genuine stress incontinence.

Furthermore, the statement that stress incontinence is "the commonest form of incontinence in adults" is not borne out by published studies. In a retrospective survey of over 1000 referrals for incontinence Feneley and others reported that combined stress and urge incontinence was the commonest symptom among women, while urge incontinence was commonest in men.[5]

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Teenage confidence and consent

SIR,—In an otherwise excellent article (12 January, p 144) on the Court of Appeal judgment which made the provision of confidential contraceptive advice to girls under 16 contrary to law, your legal correspondent failed to mention the General Medical Council's guidelines, which conflict with the law. Your correspondent's interpretation of what constitutes an emergency is very interesting. It is at variance with more liberal views expressed publicly by many eminent members of the medical profession, all of whom seem to regret the judgment. However, before we so roundly condemn their Lordships for creating a rigid and insensitive framework within which we have to work, I believe we should look at the General Medical Council's guidelines. The blue pamphlet[1] states on page 20, paragraph 4:

> Where a minor requests treatment concerning a pregnancy or contraceptive advice, the doctor should particularly have in mind the need to avoid impairing parental responsibility or family stability. The doctor should assess the patient's degree of parental dependence and seek to persuade the patient to involve the parents (or guardian or other person in loco parentis) from the earliest stage of consultation. If the patient refuses to allow a parent to be told, the doctor must observe the rule of professional secrecy in his management of the case.

The choice of the word "must" rather than "should" in the last sentence precludes a doctor from exercising clinical judgment in a case where the best interests of the girl might be served by telling her parents against her wishes that she has sought contraceptive advice. This seems no less rigid than the Court of Appeal judgment.

At present a GP who is asked by a girl under 16 for confidential contraceptive or abortion advice is faced with only three possible options, each of which carries a medicolegal risk. The options are: (*a*) maintain professional secrecy and risk prosecution (? jail) under the criminal law; (*b*) break professional secrecy and risk being admonished (? erased) by the General Medical Council; (*c*) refuse to give the girl any advice at all and risk a fine from a service committee for breach of the NHS terms of service.

This ridiculous state of affairs will not be cured by a simple reversal of the Appeal Court judgment by the House of Lords. I believe that the medical profession should press the General Medical Council for a more precise use of words in its guidelines and consider supporting an urgent review of the Sexual Offences Acts by parliament. A lowering of the age of consent to sexual intercourse would bring the statutory law into line with what seems to have become common practice. This would help to enable the medical profession once again lawfully to provide confidential contraceptive advice to those girls of (?13), 14, and 15 who apparently need it, while at the same time permitting a tightening up of the criminal code to protect the right of parents to know what is being done to their young children.

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SIR,—May I comment on your extended account of the Gillick case (12 January, p 144) by summarising our own experience. Soon after she was 16 our daughter attended a local family planning clinic and started taking an oral contraceptive. Because of increasingly frequent and severe headaches, which she had not previously had, she went back to the clinic expecting (as we also were) a change of formulation. She was told by a senior member of the medical staff that oral contraceptives "never" cause headaches, contradicting what my daughter had previously been told at the same clinic; that she was probably having migraines, cited in the data sheet as a reason for "stopping oral contraception immediately"; and that it was a question of the pill or pregnancy—no other methods were mentioned. It was also suggested that my daughter should adopt continuous use of the pill during the summer so that she could swim whenever she wanted to. Her formulation was not changed. I do not believe that my daughter's experience is an isolated example. I consider there are real dangers inherent in the unbridled and uncritical enthusiasm for oral contraceptives to which she was subjected.

Like most other doctors, I am concerned about many of the possible consequences of the Court of Appeal decision in the Gillick case. As a parent, I feel my daughter's experience (and she happened to be over 16) only strengthens Mrs Gillick's hand.

ANONYMOUS

SIR,—I am writing to you in connection with the recent Appeal Court decision in the case of Mrs Victoria Gillick. It is clear that this decision, if allowed to stand unchallenged, will pose a very serious threat to the health of many young patients. Sadly, both Mrs Gillick and the Appeal Court judges have failed to take account of a number of simple but important facts. Firstly, most young patients who approach their doctor for contraception are already sexually active. Secondly, few young patients are deterred from having sexual intercourse by the thought of unwanted pregnancy. Thirdly, many young patients do not have a sufficiently good relationship with their parents to be able to

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