When a benefit has been proved it has usually been only in terms of survival, no effect on the signs of the disease being observed. Ethylene gas and ethylene dinitramine produced a marked increase in regeneration both in injured muscle and in dystrophic muscle.[6] Only minimal improvement in hind-limb power was, however, observed. In no instance is the mode of action of these different agents clearly understood, but of more primary importance is whether similar benefit can be found in human muscular dystrophies.

R. S. Pope, in a presentation at the Jackson Laboratory in 1970, reported that glucagon produced a dramatic clinical benefit in the severity of the disease in dystrophic mice as well as a significant improvement in survival. In an intraperitoneal dose of 0·01 mg/day the mean survival (ST_{50}) was increased from 17 weeks in control animals to 39 weeks in those treated with glucagon. Since this study was not a blind controlled trial we have undertaken such an investigation.

Dystrophic mice of the Bar Harbor 129 Re strain were kept in cages with a normal litter mate of the same sex. Immediately affected animals were recognized at 2 to 4 weeks of age they were allotted alternately to treatment groups A and B. There were 12 dystrophic mice in each group receiving an intraperitoneal injection 5 times weekly of 0·1 ml of a solution either of glucagon in diluent (containing 0·01 mg glucagon in 0·1 ml) or of diluent alone. The glucagon solution and placebo were kindly prepared by Mr. W. T. Wing, Hospital Group Pharmacist of the Newcastle University Hospitals Group, and the code was broken only at the completion of the study.

The ST_{50} of the group receiving glucagon was 125 ± 87·6 days (mean ± S.D.) and the mean maximum weight gain was 3·8 ± 1·97 g. The values of these parameters in the placebo group were 113 ± 62·7 days and 4·7 ± 3·20 g. There was no statistical difference between either of these values nor was amelioration in the severity of the disease observed. Thus we cannot support Pope's suggestion of the beneficial effect of glucagon. However, trials such as this must continue until agents effective in the treatment of human muscular dystrophies are found.—We are, etc.,

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Termination of Pregnancy

SIR,—Professor H. C. McLaren (17 June, p. 714) and Professor Sir John Stallworthy (personal communication) seem to agree that long-term prospective observations are needed to assess any delayed emotional and physical effects from pregnancy termination. It is to be hoped that this will soon be initiated by the Department of Health, for no single hospital, general, or private practice study can be judged truly representative if we are dealing with upwards of 120,000 abortions each year in Britain.

Individual surgeons should, and at present may not, keep full, accurate, and honest records of each abortion procedure and the 24-hour postoperative recovery period. In most cases now the patient will agree to a report being sent to her registered general practitioner whether or not he referred the patient in the first place. By this means we may be able properly to assess possible sequelae and their causation.

On another aspect, Dr. P. Moxon (10 June, p. 655) is probably correct in suggesting that abortion is being used as a contraceptive method. Many younger unmarried women are no longer fearful of the abortion procedure and are unaware of its potential consequences. Some regard the operation too lightheartedly and need to accept greater responsibility in their sexual activities. Certainly we are seeing repeated abortions because contraception is inadequate, unacceptable, or simply not practised.

Patients should be better informed of the more modern intrauterine contraceptive methods such as the Dalkon shield or the 25S Saf-T-Coil device. Experience has shown the shield to be well accepted, expulsion and removal rates in specialized practice being almost zero while pregnancy rates should not be more than 1-2%. The pattern of menstruation is affected very little by this particular device, but it does require expert insertion technique. The shield has been fitted on the operating table immediately after uterine evacuation by curettage in 16 patients in a pilot study included in the series of pregnancy terminations I reported recently (22 April, p. 228). After nine months there have been no pregnancies and no expulsions and only one device removed. Continued menstruation has been relatively normal.

The adoption of contraceptive measures at operation should be considered more often when there are the proper indications. Otherwise insertion of the shield during the first menstrual period following abortion is strongly recommended, particularly in multiparae, whereas the 25S Saf-T-Coil is very suitable for nulliparae. The recent survey on sexual behaviour in Aberdeen undergraduates Drs. C. McCance and D. J. Hall (17 June, p. 694) confirms that improved intrauterine contraception is not being properly utilized by patient and doctor alike.—I am, etc.,

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Environment for Mental Patients

SIR,—In your leading article (12 August, p. 366) you state that the problem of the institutional needs of the mentally subnormal "must be divided between those people requiring treatment as such and those whose primary need is care." You go on to assert. "The latter fall more into the realm of the educationalist and sociologist and should be coped with outside the hospital system." I suggest that, on present evidence, the only place that most mentally subnormal people are likely to receive real *community* care in the foreseeable future is within the much criticized existing mental subnormality hospitals.

It was unfortunate in 1948 that, in their desire for improved status, mental deficiency colonies adopted the more prestigious term "hospital" and laid themselves open to the justifiable charge of sociologists and others that many of their residents did not require *hospital* care. It does not follow, however, that they do not require care in a sheltered environment such as colonies provided, within which they can live a much fuller and freer life than may be possible in a hostel in an urban area in which they are, in effect, isolated by their own limitations from full participation in the life of the area.

I suggest that parents' support for village communities for the mentally handicapped, provided by non-statutory organizations, indicate that they recognize the benefits of this type of care for children and adults who are incapable of greater independence and that these benefits should be recognized by the Department of Health and Social Security also by a return to the concept of the colony, embracing both the therapeutic and caring aspects referred to in your leading article.—I am, etc.,

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Care of the Mentally Sick

SIR,—"Planning for Disaster" is the title of the leader which follows that of "Care of the Mentally Sick" (1 July, p. 3), and this indeed could become a melancholy footnote to the whole enterprise unless the planners show more restraint and circumspection before pressing on with the new policies such as closure of the mental hospitals.

Are there any other countries at present afflicted with this urge to get rid of all their mental hospitals? In 1961 Dr. Kathleen Jones, then of the Department of Social Administration, University of Manchester, cited twelve critical factors in a symposium on "The Future of Mental Hospitals" (with particular reference to Ministry of Health Circular H.M. (61) 25). All these factors remain relevant, but I will quote only three: (1) Growth of community services in the next few years is unlikely to be adequate. (2) General hospital psychiatric units are unsuitable for treatment of majority of patients. (3) Demand for decline of mental hospitals springs largely from irrational and unacknowledged sources—with psychological and economic motives.

Is there something now developing in the social climate of Britain which uniquely makes mental hospitals unnecessary?—I am, etc.,

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Discharge from Psychiatric Hospitals

SIR,—I am sure that Dr. J. A. Whitehead's letter (5 August, p. 353) is a welcome attempt to clarify an intricate problem. May I point out that I did not refer in my letter (15 July p. 174) to a single local authority. In the case of my patients there are 11 local authorities involved from places as far apart