broad conclusion as that "there is no justification for removing a normal appendix in pregnancy". This has certainly not been the recent experience in Oxford.

Of 75 patients operated on for suspected acute appendicitis in pregnancy in Oxford, the diagnosis was found to be correct in 56. In this latter group four fetal deaths occurred and two patients went into premature labour but were delivered of infants who survived. In a further patient the appendix was the site of gross decidual endometriosis undergoing degenerative changes, which was thought to be the cause of the patient's symptoms. This patient also miscarried. However, there were no fetal deaths or cases of premature labour in 18 patients in whom the appendix was normal or fibrotic and was removed.

Most reports in the recent literature[1-5] dealing with larger series of patients are in agreement with these figures. It would thus seem reasonable for any surgeon or obstetrician faced with negative findings at laparotomy for suspected acute appendicitis in pregnancy to remove the appendix, provided it is readily accessible, as any subsequent attempts at appendicectomy may be rendered more difficult by adhesions resulting from the original laparotomy.—I am, etc.,

D. R. A. FINCH

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1 Kurtz, G. R., Davies, R. S., and Spoul, J. D., *Obstetrics and Gynecology*, 1964, **23**, 528.
2 Lee, R. A., Johnson, C. E., and Symmonds, R. E., *Journal of the American Medical Association*, 1965, **193**, 966.
3 McCorriston, C. C., *American Journal of Obstetrics and Gynecology*, 1963, **86**, 593.
4 O'Neill, J. P., *Australian and New Zealand Journal of Obstetrics and Gynaecology*, 1969, **9**, 94.
5 Thomford, N. R., Patti, R. W., and Teteris, N. H., *Surgery, Gynecology, and Obstetrics*, 1969, **129**, 489.

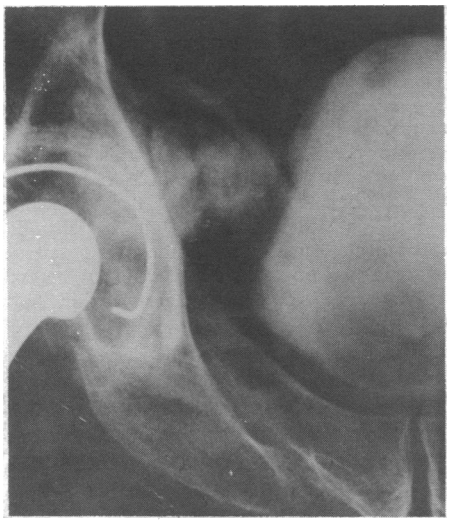
Possible Hazard of Polymethyl Methacrylate

SIR,—I was interested to read of the cases of bladder carcinoma and "cystitis of unknown aetiology" reported by Dr. R. Routledge (24 February, p. 487) in workers making polymethyl methacrylate contact lenses.

I have recently seen a patient with a bladder carcinoma adjacent to intrapelvic cement (polymethyl methacrylate) following a Charnley total hip replacement.[1] The patient had developed symptoms of increased frequency and nocturia three months after hip replacement following three years of disabling osteoarthritis. After failure of conservative measures to control his "prostatitis" cystoscopy was performed and a semi-solid tumour (transitional cell carcinoma W.H.O. Grade III) was found at the site of displacement of the bladder by the cement of the arthroplasty (see fig.) The rest of the bladder was normal.

A possible relationship between the intrapelvic cement and the bladder carcinoma could be explained on a physical or chemical basis. However, tumours produced in experimental animals by implantation of methyl methacrylate and other polymers have usually been sarcomatous,[1] while urothelial tumours caused by mechanical irritation have followed intravesical introduction of foreign bodies.[2]

That no similar cases have been described may be correlated with the length of time necessary for polymer breakdown and excretion of breakdown products[1] but the latent period in this patient could have been shortened by heavy smoking and high analgesic intake, both described as having an association with urothelial malignancy.[3-5] —I am, etc.,



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1 Oppenheimer, B. S., Oppenheimer, E. T., Danishefsky, I., Stout, A. P., and Eirich, F. R., *Cancer Research*, 1955, **15**, 333.
2 Mobley, T. L., Coyle, J. K., Muayad Al-Hussaini, and McDonald, D. F., *Investigative Urology*, 1966, **3**, 325.
3 Lea, A. J., *Lancet*, 1966, **1**, 590.
4 Angervall, L., Bengtsson, U., Zetterlund, C. G., and Zsigmond, M., *British Journal of Urology*, 1969, **41**, 401.
5 Taylor, J. S., *Medical Journal of Australia*, 1972, **1**, 407.

Kidney Donation and the Law

SIR,—Your legal correspondent (11 August, p. 360) certainly does not lack the courage of his convictions. Considering the number of conflicting opinions that he quotes, his final sentence—"It (the Human Tissue Act 1961) is not as difficult as many suppose"—is a statement as remarkable as his certainty regarding its interpretation.

I am not concerned in this letter to argue whether his interpretation is right or wrong, though I certainly question his wisdom in expressing it so emphatically. My purpose is twofold. First, in an area of admitted ambiguity, it is regrettable that your legal correspondent should have thought it relevant, or for that matter desirable, to criticize the Medical Defence Union for passing on to its members the best legal advice it could obtain, even going so far as to attribute to the M.D.U. an opinion which he knew full well was that expressed by leading counsel (in fact two leading counsel on two separate occasions). In parenthesis it is curious that he should have chosen to express this criticism just when that opinion had been supported by Sir Keith Joseph.

Secondly, I do not see what good purpose would be achieved by pursuing his suggestion that "the time has now come for the M.D.U. to reconsider the wording of the Act". In the absence of a judicial decision this could result in nothing more than yet another legal opinion, of which there is already a plethora.

What is necessary is what five members of the MacLennan Group, including its chairman, recommended[1] and what I myself urged in a letter published in the B.M.J.[2]—namely, an amendment of the Act to remove the ambiguities.—I am, etc.,

PHILIP H. ADDISON
Secretary,
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London, W.1

1 *Advisory Group on Transplantation Problems*. London, H.M.S.O., 1969, Cmnd. 4106.
2 Addison, P. H., *British Medical Journal*, 1968, **1**, 516.

**Our legal correspondent observed that "The M.D.U. was advised by leading counsel. . ."—ED., *B.M.J.*

Kidney Donor Cards

SIR,—In your leading article (28 July, p. 189) you mention kidney donor cards and regret the lack of publicity about them. May I suggest that one of the pages for endorsements in all future driving licences be omitted and replaced by a statement signed by the new licensee and his or her next of kin offering to give his or her kidneys in the event of a fatal accident. This document is generally available on the person of the victim(s) and it could also so easily carry the blood group and the G.P.'s telephone number.—I am, etc.,

R. A. C. MCINTOSH

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Redesign of Medical Records in General Practice

SIR,—I refer to Dr. L. D. Church's letter (28 July, p. 234). In 1971 I studied records in general practice with the assistance of an Upjohn Travelling Fellowship, and the outcome was an A5 record envelope. A synopsis of this report is to be published in the Journal of the Royal College of General Practitioners shortly. In essence, my findings were that a new record system was essential and any change should adhere to the New International Paper Sizes. In practical terms this meant that the new record would either be A5, the size of the ordinary hospital letter, or A4, the size of a large hospital letter or foolscap size. It was my view that A5 in a double-wallet record form and guessetted would be ideal for practice. I was dismayed to learn that the A4 size had been accepted in principle by the Department of Health and Social Security as these new records will be large, bulky and unwieldy. Less than 5% of patients have large dossiers.

Now that the profession has had an opportunity of considering these record sizes I hope that the Department will reconsider the situation and choose the smaller A5 record. Doctors using a lateral filing system would find that the A5 record can be filed without any difficulty or any changes being made to existing shelves.—I am, etc.,

A. J. LAIDLAW

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SIR,—It can be assumed that the advocates of A4 records in general practice write good notes. It is difficult to believe they write bad