usually refers to the destruction of the fetus per se. But as Dr. Wilkinson points out, many doctors conscientiously consider the needs of the whole person, allowing for the possibility that these needs may conflict with the patient's immediate demands. In my view these two issues are not distinct from each other; the destruction of the fetus must rarely be compatible with the whole patient's needs. If a woman (in one way way or another) procures an abortion, this indicates that we, as doctors, relatives, or citizens, have been failing to help her.—I am, etc.,

P. S. HUGHES

London N.7

Scene on T.V.

SIR.—I thoroughly enjoyed the T.V. picture of the young doctors' walk, and the organizers are to be congratulated. They got a nationwide free advertisement for which commercial firms would have to pay hundreds of pounds. They were "news."

Not far from where this is written is an arbour now sheltering teetotal water-loving plants in a peaceful park. Up to a hundred years ago it was the temporary residence of the Vic Feather of the day. He sat in state while the local guilds marched past (somewhat unsteadily!) carrying the emblems of their various trades. These "walks" became too rowdy and died from disrepute. The T.V. young doctors were quite in line wearing white coats and stethoscopes—the symbols of their craft—but they were not rowdy and the well-known dignity and honour of our noble profession emerged unscathed. I really mean this for it is a noble, hardworking, kind profession. Maybe the extra push of our young bloods may have helped in influencing the Government to agree to set up an inquiry.—I am, etc.,

ALBERT E. NICHOLLS

Shrewsbury

Geriatric Accommodation in Acute Illness

SIR,—The problem of admitting to geriatric wards acutely ill old people at short notice is a complex and difficult one, more especially since the need in these patients is often for basic care and not highly skilled and technical therapy.

Nevertheless, it should be possible to provide this service within the existing hospital framework rather than resort to the use of short-stay reception centres as suggested by Dr. J. A. Frais (18 November, p. 424). Geriatric departments should aim to provide an emergency service as part of their total concern for old people. It may be necessary to restrict this part of their service to patients over a certain age. In our department an emergency service is provided for patients aged 75 years and over.—I am, etc.,

R. TEPPER

Bolton District General Hospital,
Bolton, Lancs

SIR,—Dr. J. A. Frais (18 November, p. 424), in his recommendation that acutely ill old people require only second-class accommodation in "reception units," displays a similar rejection with regard to the elderly to that which he deplores in others. Most elderly sick patients have a common feature —i.e., helplessness, which is often associated with temporary mental confusion and incontinence. Such patients require great skill and humanity in nursing if improvement and care are to be achieved and chronicity prevented.

Helpless elderly patients need, incidentally, the best type of hospital accommodation with all modern nursing aids if the problem of their helplessness is to be overcome. More attention should be paid to the deployment of available hospital beds, and this involves a review of the internal administration of the hospital service. Many old people today are unnecessarily admitted to hospital owing to poorly thought out new town development, the quality of which suggests that neither architects nor town planners are aware of the fact that one in eight of the population today is over 65 and needs a specifically tailored protected environment. It is necessary also to motivate both general practitioners and relatives towards caring for as many old people as possible at home.—I am, etc.,

WILFRED FINE

Liverpol

Torsion of the Testicle Again

SIR,—Your leading article (2 December, p. 505) prompts me to describe a recent experience which gives further food for thought.

A young man was admitted on my unit six months ago with a diagnosis of torsion of the testicle. The diagnosis was upheld and his testicle explored. No torsion was found but the testis was described as being slightly enlarged. The enlargement was assumed to be inflammatory. His postoperative course was uneventful but when the enlargement had failed to subside three months later he was readmitted and a seminoma removed. —I am, etc.,

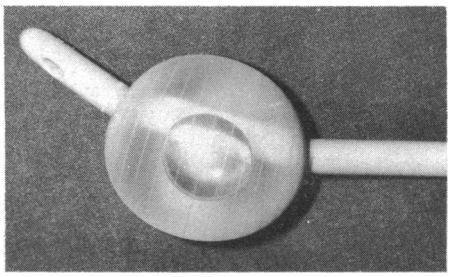
ROBIN BURKITT

Ashford Hospital,
Ashford, Middlesex

Removing Obstructed Balloon Catheter

SIR.—Difficulty in removing a self-retaining catheter from the bladder may arise from inability to deflate its balloon. When aspirating the fluid within the balloon fails it has been recommended[1] that either 5-10 ml of liquid paraffin or 2-5 ml of chloroform should be injected into the balloon, flushing the bladder after the catheter has been removed. Both methods have disadvantages. Chloroform or liquid paraffin may cause chemical injury to the bladder mucosa and retained fragments of balloon will induce bizarre foreign body reactions. Inflation of the ballon above its capacity and forceful traction as methods of removing an obstructed catheter may be mentioned only to be condemned for obvious reasons.

We have found that removal of obstructed self-retaining balloon catheters may be achieved by introducing the stylet of a ureteric catheter into the balloon channel after severing the valve and advancing it until it reaches the balloon. The stylet is then removed. This re-establishes the patency of the channel, and in every case the balloon empties unaided. The catheter is then gently withdrawn from the bladder. We always find that the balloon is intact and distends symetrically (see Fig.) The technique is



simple, safe, causes minimal discomfort, and it ensures rapid deflation.

We wish to thank Dr. Evan Griffiths for his help and encouragement.—We are, etc.,

S. C. SOOD
H. SAHOTA

Maelor General Hospital,
Wrexham

1 Warne Surgical Product's Limited. Personal communication.

Forms For Hospital Investigations

SIR,—Full access to hospital investigations through the pathology, *x*-ray, and electrocardiographic departments has enabled the general practitioner to offer his patients a higher standard of care and has given him increased work satisfaction.

I think it is now time to standardize the different request forms used by the various hospitals and to see that their size is suitable for the medical record envelope. In my practice we have open facilities at four local hospitals, and if a patient has regularly been seen at one hospital it makes sense to have his *x*-rays or other investigations done at the same hospital, so that the reports may be readily available should they ever need to attend the consultant in that hospital again. At the present time, if one uses a form from another hospital to do this, the request is usually carried out only after a scream of rage from the department concerned.—I am, etc.,

RONALD LAW

London, N.W.10

Diagnostic Radiologists in Distress

SIR,—The B.M.A. Radiologists Group Committee, which now represents the interests of almost 1,500 radiologists, continues to strive to put their interests before professional negotiating bodies and the Department of Health and Social Security. We have tried very hard to obtain a revision of the regulations relating to categories I and II, following the disastrous H.M. 71/2,[1] which came into effect on 1 February 1971. "At a stroke" this removed considerable remuneration from many radiologists, pathologists, and chest physicians. So far as radiologists are concerned, this remuneration is of considerable importance. Many radiologists are overworked, and this extra remuneration was in many cases the only reason why a post in a regional hospital remained filled. At the present time there are nearly 100 vacant and unfilled posts in radiology, and many radiologists when they qualify emigrate to North America, where