

tary proteolytic enzymes. Each patient should ideally be assessed individually by measuring the optimum amount of protein they can manage to achieve positive nitrogen balance. Excessive protein in the large bowel may merely exacerbate the symptoms which the low-fat diet has been introduced to control.—We are, etc.,

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Side-effects of Phenindione

SIR,—I was interested to read Dr. D. C. Lyon's case report of intussusception complicating phenindione therapy (11 May, p. 345), and no doubt, as he suggests, the increasing use of long-term anticoagulants as an adjunct to the management of such common conditions as coronary thrombosis, cerebrovascular accidents, thrombophlebitis, and recurrent pulmonary embolism makes an awareness of the possible hazards of such therapy important.

Minor side-effects, such as fleeting skin rashes during the first 10 days, and discoloration of the urine, have been described since the early days of its use and can be ignored.¹ In 1966 three cases of paralytic ileus in patients on phenindione therapy were reported,² and later A. G. Nash reported a similar case.³ We could find no cause to explain the occurrence of paralytic ileus in these patients,² and it was suggested that the ileus was due to the toxic effect of phenindione, and may have relevance to the suggestion of Burns and Desmond,⁴ that sensitivity to phenindione may be due to the presence of a potentially toxic modified benzene ring in the compound.—I am, etc.,

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Ethics and Abortion

SIR,—As Mr. John Frampton has pointed out in your columns (4 May, p. 298), arguments among colleagues on their approach to social indications for abortion are inevitable. My colleagues in the professional unit here try to evolve "policies," but often there is honest doubt, and the patient is then admitted for full clinical examination and perhaps mild sedation to ensure sleep. The final decision is taken by a team starting with the family doctor, the gynaecologist, and usually a consultant psychiatrist. Full clinical appraisal takes note of the social pressures deemed to be making an impact on the patient's health. Just how much account is taken of these social factors naturally varies from one hospital colleague to another, and equally from one family doctor to another. In the final decision the gynaecologist must obviously be in agreement before consenting to operate. If the patient disagrees with the opinion of the medical team then she is directed to

another respected consultant, provided her family doctor is in agreement.

But even whole communities may differ considerably in their approach to abortion. Thus two cities, each offering a high standard of medical ethics and obstetrical care, may differ widely. For example, Aberdeen carries out abortion or abdominal hysterotomy in one in 50 pregnancies. In Glasgow¹ the rate is one in 3,750, and without doubt social and economic pressures in the slum areas of Glasgow overshadow Aberdeen. No doubt in ten years Aberdeen and Glasgow will have rethought their policies, and left to themselves, with their long-term results available, they will reach correct decisions for the future. But will they be left to work out the proper role of abortion as therapy? Already in the Midlands hospital and private abortion practice are in competition. A telephone number is freely available in Birmingham to a so-called "social worker" who in turn will pass the name and address of a "sympathetic doctor." This private group, headed by the local chairman of the Abortion Law Reform Association, also plan a private abortorium with surgical help imported from another city on a fee-for-service basis.

Thus my colleagues and I in hospital practice have outpatient appointments made by our colleagues in family practice with a postscript to the letter asking for an appointment as follows: "I do not expect she will turn up—she waved the Pregnancy Advisory Bureau pamphlet at me as she departed!" So we still have the Abortion Law Reform Association working hard in a new guise for easy abortion-on-demand for healthy women under social or economic pressure. If the N.H.S. will not provide this an abortion service (for suitable fees) can be arranged. All that is required is that the nursing-home or abortorium is duly registered at the Ministry of Health. Everything turns on this permission, and the medical fraternity in the Midlands is watching the position very closely.

To the Scots and Northern Irish (unaffected by the Abortion Act) all this must sound far removed from the cool academic approach of Aberdeen, where no fees change hands and all abortions are carefully weighed and when necessary carried out in hospital, not as a social service, but as part of medical care. But perhaps Glasgow should look out for its first abortion missionaries—one abortion in 3,750 will never do.—I am, etc.,

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REFERENCE

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Mastectomy Stand

SIR,—I was interested to see the apparatus described by Mr. G. R. Clarke and others (18 May, p. 431) to facilitate bandaging after radical mastectomy. For many years now we have used a very simple device for achieving precisely the same result as the mastectomy stand following such operations as mammaplasty or the grafting of chest burns. It consists of a length of board 42 in. × 6 in. (105 cm. × 15 cm.) covered on both sides with

nylon film. This is inserted from the head end lengthwise beneath the patient's spine, and when the free edge is raised by an assistant it supports the patient's back and head as on an inclined plane. The bandages are then applied round the chest incorporating the board. Once the dressings have been secured in this way, the board is withdrawn. Preliminary greasing of the board's surfaces with petroleum jelly ensures its easy and smooth withdrawal. An advantage of this simple board technique in plastic surgery is that it may also be used to facilitate bandaging the neck and shoulders following grafting of these areas or the axillae. A further advantage is the low cost, a few shillings compared with the £35 for the mastectomy stand.—I am, etc.,

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SIR,—Following the interesting solution to the problem of mastectomy bandaging by Mr. G. R. Clarke and others (18 May, p. 431), I am prompted to suggest an alternative dressing. Two suction drains of the Redivac or Sterivac type are employed, and the wound sealed with Nobecutane and a strip of ribbon gauze. This method avoids the problem of bandaging with its disadvantages of application, reduction of chest movement, and discomfort to the patient. It has the added advantages of allowing inspection of the wound and skin flaps without removing and replacing cumbersome bandages. There is less risk of cross-infection, and the suction ensures immediate and constant apposition of the skin flaps to the chest wall with consequent improvement in the rate of healing.

The method is also applicable to operations other than mastectomy.—I am, etc.,

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Paracervical Block with Bupivacaine

SIR,—With reference to Mr. D. H. Gudgeon's article on paracervical block with bupivacaine 0.25% (18 May, p. 403), we agree that this technique provides a valuable method for the relief of pain in labour. However, we would like to draw attention to several alarming episodes of foetal bradycardia following the use of the 0.5% solution (containing 1:200,000 adrenaline) which have caused us, like Mr. Gudgeon, to abandon its use. Several cases of extreme foetal bradycardia were seen following the injection of 2 × 10 ml. of 0.5% bupivacaine into the paracervical space, one of which culminated in intrauterine death 20 minutes after the performance of the block. Since this time we have used a 0.25% solution (containing 1:400,000 adrenaline), under strictly controlled conditions of foetal monitoring, but so far without any evidence of foetal distress, and with little decrease in duration of action.

There would therefore appear to be no good indication for using the stronger solution, and indeed it may be positively contraindicated.

The suggestion that the adrenaline contained in the solution may be responsible for these effects, perhaps by interfering with the utero-placental circulation, is under investigation. It is of interest to note that analgesic solutions without adrenaline have also been shown to cause foetal bradycardia.¹