and among this group of patients there is a higher instance of endometrial hyperplasia.

So much for cancer of the endometrium—that is, cancer of the corpus uteri. "The pill" is known to alter the cytology of a cervical smear, but there is still no evidence that it causes carcinoma of the cervix. Anyway, unlike the endometrium, the health of the cervix can so easily be watched by means of frequent cervical smears. The cause of carcinoma of the ovary remains a mystery, and even the most enlightened research worker would find it difficult to connect the cause with "the pill."

To summarize: From the cancer point of view it is my opinion that those women using "the pill" as a contraceptive may be thoroughly reassured. But in so doing, of course, it must be firmly remembered that intermenstrual spotting, a common side-effect in patients using "the pill" regularly, should be regarded with some suspicion.—I am, etc.,

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Treatment of Fits in Childhood

SIR,—Your emphasis on establishing and maintaining a good airway is welcome (17 April, p. 1012).

Phenobarbitone is unsuitable for immediate control because when given in adequate dosage it is liable to cause respiratory depression, and barbiturates can cause vomiting, as Carnegie notes in a valuable review of this problem.[1]

For the newborn chloral and for older children paraldehyde is preferable, as described by Carnegie.[1] The dose recommended by the Clevedon Study Group was 0.2 ml./kg. body weight.[2] McGreal[3] advised 0.3 ml./kg. Sterile paraldehyde in sealed glass ampoules and a glass syringe are used. They are desirable items in every general practitioner's bag.

In a hospital ward or casualty department, once the airway is established, blood should be taken for later blood-sugar estimation and glucose given intravenously. If there is no response in two minutes then paraldehyde is given.

Shanks[4] recommends giving phenytoin 50–100 mg. intramuscularly in addition to the paraldehyde. It has a slight stimulant action on the respiration.—I am, etc.,

London S.W.1. RONALD MAC KEITH.

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1 Carnegie, D. M., *Develop. med. Child. Neurol.*, 1964, **6**, 183.
2 Bax, M. C. O., and Mitchell, R. G., *Acute Hemiplegia in Childhood*, 1962. Spastics Society and Heinemann, London.
3 McGreal, D. A., *Practitioner*, 1958, **181**, 719.
4 Shanks, R. A., *Cerebr. Palsy Bull.*, 1961, **3**, 583.

SIR,—Your editorial on this subject (17 April, p. 1012) once more enshrines "febrile convulsions" as a diagnostic category. May I suggest that fever is only one of a number of physiological upsets which may precipitate a fit—often more readily in children than in adults. It should be regarded simply as one occasion for fits of which the cause is either a pre-existing local brain lesion or "idiopathic" epilepsy (the term is used with a realization of its shortcomings). "Febrile convulsions" may be adequate phenomenology; as a diagnosis they should follow "teething convulsions" into the discard, and make way for a more rational approach to the diagnosis of fits in childhood.

This is not an argument for labelling as epileptic all those who have an occasional fit in childhood: only a plea for distinguishing clearly between description and diagnosis in medicine.—I am, etc.,

C. W. M. WHITTY.
The Radcliffe Infirmary, Oxford.

SIR,—Your leading article on this subject (17 April, p. 1012) does not mention hypoglycaemia as an aetiological factor. It is, of course, an important, though perhaps uncommon, condition which requires prompt treatment to prevent cerebral damage. A baby with convulsions should be immediately admitted to hospital, where an estimation of blood glucose should be included among other urgent investigations (serum calcium and C.S.F.).—I am, etc.,

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Potentially Dangerous Forms of Drug Economy

SIR,—Dr. K. S. Zinnemann in his recent letter (17 April, p. 1067) drew attention to the possible dangers of using what he considers to be inadequate doses of ampicillin (Penbritin) or tetracycline for long-term prophylactic treatment of chronic bronchitis. He stated that the manufacturers of ampicillin are not acting in the best interests of bronchitic patients in suggesting, for prophylactic treatment, one capsule (250 mg.) of ampicillin every 12 hours.

This dosage has been recommended by an eminent authority[1] and is therefore included in our literature. It is, of course, fully appreciated that the long-term, small-dose prophylactic use of antibiotics in the treatment of chronic bronchitis is controversial, and for this reason we state that "when continuous daily treatment *is considered desirable*, one capsule (250 mg.) is recommended every 12 hours." We would certainly welcome more prolonged and intensive investigation into the most effective long-term continuous therapy, and our recommendations, which are under constant review, will be changed as appropriate.

For those who consider that long-term prophylactic use of small doses is not "desirable," two other higher dosage regimes are included in our literature, and these are also based on clinical usage.—I am, etc.,

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Beecham Research Laboratories
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REFERENCE
1 Oswald, N., *Practitioner*, 1964, **193**, 735.

Abortion Law

SIR,—Your leading article (17 April, p. 1009) gave admirable publicity to the possibility of significant reform of the law on abortion and it is to be hoped it will encourage the medical profession to clarify its position on this subject. Despite a recommendation for a change in the law by a B.M.A. committee on abortion in 1963, few gynaecologists would seem to support such a measure and significantly few doctors appear to be members of the Abortion Law Reform Association.

The decision regarding the deliberate destruction of any pregnancy is one that most doctors would wish to have made by the medical profession. Few would countenance direction from the state, the law, or by the patient herself. In consequence the law relating to abortion should be so framed as best to assist doctors who are called upon to undertake these difficult decisions.

The consultation is peculiar in that the patient does not come for advice but in the hope that she will be able to persuade the gynaecologist to undertake a certain course of action. He may well agree that the pregnancy is wholly undesirable but still be uncertain regarding the ultimate effect of such procedures upon her physical, spiritual, and emotional health, upon society, and also upon himself and his assistants. The advice of the family doctor may well be of more help to him than the opinion of a psychiatrist without prior knowledge of the patient.

Fortunately the present permissive state of the law seems ideal for the exercise of impartial medical judgment. It is sufficiently forbidding to give patients proper respect for the gravity of the action they demand, while lenient enough in operation to allow doctors to act in the best interest of each patient. It would be interesting to know how many gynaecologists would alter their present practice in the event of the abortion law being changed.—I am, etc.,

Birmingham 15. WILFRID G. MILLS.

SIR,—If the medical argument on abortion were the last word it would already have been said and the matter would have lost all public interest. For, as your admirable leading article (17 April, p. 1009) made clear, the grounds for therapeutic abortion, if not unanimously agreed in detail, are amply covered by the law as it stands.

However, thanks to the skilled agitation of those who, for whatever motive, advocate amendment, the medical aspect has become almost secondary. For while on the one hand we have the learned arguments of Mr. Glanville Williams, there is, on the other, Mrs. Lena Jeger, M.P., who pleaded eloquently in the *Guardian* of 24 November 1964 for what she called "mankind's fifth freedom," the freedom to abort, as the only answer to the population explosion.

If a reform in the terms of the measure you attribute to Mr. Williams were to reach the Statute Book there is no reason to suppose that the response would be less than was the experience of Sweden. There, in the eleven years until 1961, following the introduction of a permissive law, the number of abortions, now legal, multiplied twelve times.

Gynaecologists would find themselves faced with a demand and pressure for abortions as a right, under the N.H.S. Would it not be wise for, say, the Royal College of Obstetricians and Gynaecologists to issue a definitive statement, from their immense authority in