kidney is potentially dangerous, since the method of sterilization with 2% formalin does not reach any reasonable bacterial standard. The tendency of life today is to move towards the use of disposable equipment, and the Kill is really old-fashioned and clumsy.

We have had over a year's experience now with the Lucas monitor/dialysate proportioning system and been very pleased with its operation, granting, of course, that the machine is well and properly understood. Recently we have also been very pleased with the performance of the Baxter "Ultraflo" coil used in the newest model of the Travenol R.S.P. machine, and it seemed obvious to marry the two together. Thus we have built a container capable of holding the "Ultraflo" coil, providing a continuous flow of dialysate through the coil at high rates of flow and under an adjustable negative pressure so as to make use of the Lucas monitor system. This prototype canister, made of Perspex, is functioning well, producing perfectly normal dialyses with good end biochemical figures, and achieving these results within a period of between six and eight hours.

The present cost of such a dialysis is £9, but it is good economics to keep expensive equipment steadily employed, and the possibility of two, if not three, dialyses per 24 hours instead of one is surely an advance. Further development work is proceeding. The exciting prospect, of course, is that, without any increase of beds, we may accept more patients in permanent renal failure who nowadays see a future for themselves in the steadily increasing success of renal transplant work.—We are, etc.,

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Abortion Act in Practice

SIR,—Although I am not personally involved in applying the Abortion Act, may I be permitted to enlarge on one of Dr. J. H. Hughes's remarks (8 March, p. 637)? Dr. Hughes tells us that if all doctors "put their patient's welfare before their own religious and biased cobwebbed ideas on abortion" there would be no further problem. How delightfully simple! However, to reduce the matter to such a simple level one has to make a few assumptions:

- (1) that objections to a liberal interpretation of the Act are necessarily religious;
- (2) that being religious they are demonstrably irrelevant to our present situation (which is presumably what Dr. Hughes means by "cobwebbed");
- (3) that all doctors who don't think like Dr. Hughes are more concerned about the peace of their own consciences than about the welfare of their patients;
- (4) that any who doubt the wisdom of interpreting the Act liberally are biased, whereas its enthusiastic supporters and they alone are capable of unbiased judgement; and
- (5) that what is permitted by an Act of Parliament is *ipso facto* the best for all citizens.

No doubt others of your readers found these assumptions hard to swallow.—I am, etc.,

D. C. TURK.

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University of Newcastle upon Tyne.

SIR,—Dr. J. H. Hughes (8 March, p. 637) is timely in reminding us that without the "biased cobwebbed ideas on abortion" of many doctors "the new Act would present no problems at all." It certainly is amazing to see how much time is wasted by gynaecologists and psychiatrists on sorting out a problem which from the woman's point of view, and indeed in the view of a majority in this country, should present very few difficulties.

One of my patients, a highly strung mother of four children, was recommended by me for termination. She was involved in four consultations in three weeks at a local hospital only to be refused termination in the end. Worse things are happening in the country.

While this law is the envy of Europe and by far exceeds recent reform of the law on homosexuality and the proposed reform of the divorce law, there is one flaw in it: it does not set a time limit for termination. Experienced observers like the late Professor W. C. W. Nixon have always insisted on the 13 weeks' limit for termination, being well aware of the fact that by waiting longer a relatively simple operation, requiring no more than 20 minutes of a surgeon's time and about six hours in the hospital altogether, is turned into a hysterectomy with anything from 2 to 7 days in hospital. This quite unnecessary luxury is also unpleasant in other ways—for example, the viewing of the operation by doctors and nurses. There is little to be seen in the curettings of an 8/52 pregnancy, whereas beyond 14 weeks it does look rather ugly to some sensitive staff. It seems unnecessary to provoke their feelings. Complications, according to the Swedish statistics, are also higher in terminating the more advanced pregnancies.

Last but not least, the woman who comes late with her request for termination is more often than not also the woman who cannot

make up her mind and might therefore have psychiatric complications after termination. Granted there are the inexperienced children under 18 and there is the girl from darkest Ireland, but can we model medical procedure on them? Future policy should therefore be to leave this fine liberal law as it is, but with the insertion of a time limit of 13 weeks for termination.—I am, etc.,

London S.E.17.

E. F. RICHARD.

SIR,—To say that I was disgusted by Dr. J. H. Hughes's letter (8 March, p. 637) would be a masterpiece of understatement. Indeed, I find the trendy, assembly line philosophy of the whole letter so utterly repugnant that it would take up valuable space to itemize all my objections to it.

So, as we appear to be indulging in polemics, perhaps I may be allowed to spell out what I personally believe to be true. That an embryo implanted in the uterus is a potential human being. That an abortion destroys this potential human being. That it is the duty of the profession to preserve life, and that by destroying life it takes on itself the heaviest of responsibilities. These are not "religious and biased cobwebbed ideas"—these are surely the very stuff of medical ethics.

I also fully agree with Professor Keith Simpson (15 February, p. 436), and feel strongly that advertisements for establishments which appear to proclaim their main function as the destruction of life rather than its preservation are inappropriate to a respected medical journal, and leave a particularly nasty taste in the mouth.—I am, etc.,

Wendover, Bucks.

N. C. LEE.

Overinvestigation

SIR,—I would like to add two examples to the letter by Mr. A. Dickson Wright on overinvestigation (15 February, p. 440).

A previously healthy man of 42, who had sustained some superficial war injuries—for which he was in receipt of a pension—developed blueness of the fingers with early gangrene of finger tips in 1957. He was admitted urgently to hospital and somebody thought he saw splinter haemorrhages in the nails—rather difficult in blue-black nails. A diagnosis of subacute bacterial endocarditis was made and intravenous heparin and nicotinic acid given. This apparently produced some reaction—there is no record in the heavy dossier of the war pension reviews of the length of his stay in hospital. He was so depressed—or impressed—by the serious nature of his illness that treatment by E.C.T. was ordered. Investigations on the grand scale were repeatedly carried out, including repeat x-rays of the metallic fragments—all were normal. On one occasion the diagnosis of Raynaud's disease was put forward, but, possibly as the cold agglutinins did not match up to this, no decision was made. When seen recently he stated that he was attending hospital at intervals. Phenindione was prescribed and the prothrombin time estimated every 14 days. On examination the fingers were normal and there had been no further attacks. He had changed to an indoor occupation.

I suggest that if this man had been given a continuous hot bath for an hour, or put in a very warm bed with a few drinks of alcohol, this expensive and dangerous treatment and

his loss of time and waste of hospital time could have been avoided. Also the expenses of the numerous tribunals would have been lessened.

The second example concerns a man whose carcinoma of the colon I removed several years ago. About two years before death, I removed the prostate. About two months before death he was readmitted with urinary infection. Cystoscopy, after dilating a urethral stricture, showed that the bladder was so inflamed that an accurate diagnosis was not possible. Urine was sent for examination and after treatment he was discharged to await the report. Later he was admitted to an outlying hospital and rapidly transferred to the main hospital. The house physician's notes read, "The patient is moribund and unable to give a history." What now seems to be the routine investigation was set in motion, and this included chest x-ray, blood Wassermann, gonococcal complement fixation test, blood cholesterol, complete blood chemistry, and some others I cannot remember. By the time these reports had been collected and typed the man was safely interred, and death was certified as secondary carcinoma of the lungs. The radiologists' opinion was that the lung changes were those of miliary tuberculosis. By the time I had learned of his death the result of the urine examination was available and this showed heavy growth of tubercle bacilli.

One might ask what purpose could be served by these extensive, expensive, and time-wasting investigations in a dying man. A few hours' delay for a search of the records would have made no difference to the ultimate result.

It would seem that the old-fashioned teaching which depends on the senses we have been given—hearing, speech, vision, smell, tactile appreciation, and memory—has been abandoned and a diagnosis cannot be made without routine investigation of every fluid in the body, supplemented by x-rays of various organs. From this sheaf of typewriting it is hoped that some clue may be given which may fit in with the patient's symptoms—if he has been questioned about them.—I am, etc.,

Plymouth, Devon.

EDRIC WILSON.

SIR,—The poignant case cited by Mr. A. Dickson Wright (15 February, p. 440) seems to typify a trend in contemporary therapy in which the enthusiasm of some physicians for modern scientific methods blurs their imaginative faculty in respect of the patient's condition.

One would like to suggest that an "advance declaration," copies of which could be deposited with one's family doctor, solicitor, and nearest relative, might be a reasonable procedure so that in the event of terminal illness or irreparable damage to brain or other organs, where life can only be sustained by artificial means, the physician in charge would have some ethical guidance as to whether to resuscitate, investigate, or *requiescat in pace*.

Such a declaration would, of course, at present be non-statutory, but the Euthanasia Society of London hopes to incorporate a form of "advance declaration" in a Bill for the legalization of voluntary euthanasia which the Society hopes will be debated in Parliament in the near future. In this way a stricken patient would at least have the expectation of dying with dignity.—I am, etc.,

MAURICE MILLARD.

Member of Executive Committee,
Euthanasia Society.

Leicester.

Draining Loop Colostomy

SIR,—The traditional loop colostomy when used in the management of acute large bowel obstruction can cause difficulties in nursing care particularly with regard to dressings. Paul's tube provides a closed drainage system, though it can become blocked or dislocated. Other ways of managing such a colostomy

ence of the plastic ring are removed. The glass rod (the ends of which are covered with rubber tube) is placed across the ring and located in the slots, having first been passed through the mesentery of the colon. The colostomy plate is then stuck to the skin and the bag placed in position. This arrangement is neat and keeps the patient comfortable, provided that there is

have been described, and recently, Mr. W. M. Keynes (18 January, p. 187) discussed the use of colo-cutaneous suturing. However, I have found that adequate control of faecal material may be achieved by modifying one of the disposable colostomy/ileostomy appliances now available.

The opening in the plate is cut to the correct size and two small segments of the circumfer-

satisfactory adhesion between the skin and colostomy backplate.

I have found that this improvised appliance works well and frequent dressings are avoided.—I am, etc.,

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Is Quinidine Outdated?

SIR,—There appears to be some confusion regarding the conclusions my colleagues and I came to concerning the use of quinidine. Unfortunately the paper we published¹ in which we gave our reasons for preferring direct-current shock to quinidine for reverting paroxysms of arrhythmia to sinus rhythm is not quoted either in your leading article (8 February, p. 331) or by Dr. C. P. Petch (22 February, p. 507) who takes issue with us. The paper to which they both refer, by Dr. J. P. H. Davies and myself,² is not concerned with quinidine as a means of reverting arrhythmia to sinus rhythm, but we did undertake a random trial of that drug as a means of maintaining sinus rhythm. It was our unpleasant experience from this trial which prompted us to publish the paper referred to above entitled "Quinidine-induced Syncope." We made it clear that we do not consider quinidine is as yet completely outdated and our conclusions were: "Unfortunately sinus rhythm, whether induced electrically or by quinidine, may not be permanent, and it must be admitted that there are a few patients who are so acutely aware of their paroxysms of arrhythmia that not only their daily life but also their sleep is seriously interfered with; they can obtain respite only from continuous oral quinidine. In our view there is no indication to treat any paroxysm of arrhythmia with quinidine, and direct-current shock is strongly to be preferred, but there is a small place still for its use as a preventive of paroxysms until a safer drug is discovered."

"We would emphasize that precautions regarding quinidine therapy . . . may all be carried out carefully and yet the patient may suddenly and unexpectedly die."—I am, etc.,

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REFERENCES

- ¹ Davies, P., Leak, D., and Oram, S., *Brit. med. J.*, 1965, 2, 517.
- ² Oram, S., and Davies, J. P. H., *Lancet*, 1964, 1, 1294.

Pulmonary Oedema following Immersion in Sea-water

SIR,—In his admirable article on drowning (7 September, p. 597) Surgeon Rear-Admiral Stanley Miles states that pulmonary oedema following inhalation of water may demand treatment by positive pressure oxygen ventilation. We describe the case of a patient, recently treated by us, in whom this proved effective.

A woman aged 52 fell overboard into sea-water while drunk. She was rescued, expired air resuscitation was commenced, and she was taken to the local hospital and seen by one of us (M.G.H.). She was extremely cyanosed and there was no spontaneous respiration and no palpable pulse. No heart sounds could be heard. Endotracheal intubation was performed (9 mm. cuffed tube) and the lungs inflated with 100% oxygen. Hydrocortisone 100 mg. and frusemide 20 mg. were administered intravenously and cardiac compression continued.