- ² Little, P. J., and Bailey, R. R., *New Zealand Medical Journal*, 1970, 72, 183.
³ Mahon, W. A., Wittenberg, J. V. P., and Tuffnel, P. G., *Canadian Medical Association Journal*, 1970, 103, 1031.
⁴ Fabre, J., Pitton, J. S., and Kunz, J. P., *Chemotherapy*, 1966, 11, 73.

Hypoxic Newborn Infants

SIR,—The paper by Dr. M. A. Chadd and others (27 November, p. 516) appears to lend support to other work on the effects of birth asphyxia on haemostasis in the new born.¹ However, in fairness to themselves I feel that the authors should correct a number of inconsistencies which occur in their paper as published.

The study purports to be on full-term infants, but yet in Table I the mean gestation of the hypoxic group is given as 35.1 weeks and that of the controls as 35.5 weeks. Antenatal complications (Table I) are recorded as $46 \pm 10.2\%$ (hypoxic) and $17 \pm 7.8\%$ (control). Surely antenatal complications were or were not present in each case? There is no mention of what antenatal complications were recorded.

Rectal temperature below 35°C in the first 24 hours (Table I) is recorded as $4 \pm 4.1\%$ for the hypoxic group and $25 \pm 8.8\%$ for the control group. Again it is difficult to see what these figures mean and any interpretation put on them seems incompatible with the text statement that a rectal temperature below 35°C was detected in a greater proportion of hypoxic babies (as compared with control babies).

The statement in the discussion that this work suggests that "disseminated intravascular coagulation is a frequent factor of major importance in infants who die shortly after birth with haemorrhage" hardly seems justified in a paper devoted to babies with low Apgar scores in whom "there was no overt evidence of haemorrhage." Finally, the statement in the summary that "the consumption of clotting factors . . . led to the appearance of an haemorrhage diathesis" is at variance with the clinical findings reported.—I am, etc.,

J. S. WIGGLESWORTH

Institute of Child Health,
Neonatal Department of the Institute,
London W.12

- ¹ Chessells, J. M., and Wigglesworth, J. S., *Archives of Disease in Childhood*, 1971, 46, 253.

Plastic Stitch Holder

SIR,—During the operation of anterior resection of the rectum interrupted stitches are usually used for anastomosing the bowel. The ends of each stitch are left long and held with artery forceps, to be tied at the end when all the stitches are in position. The assistant has to hold the forceps in order and on a slight stretch so that the thread does not get tangled or twisted.

A plastic stitch holder may be used for this purpose. This will leave the assistant's hand free. The stitch holder is pinned to the green sheet covering the patient, using a safety-pin and placed in a suitable position near the edge of the wound. The ends of each stitch are slipped in a slit in the stitch holder (Fig.).

The plastic stitch holder can be made from the disposable plastic container of a Foley's catheter; approximately 18-20 cm length from the sealed end of the plastic container is ideal for this purpose. The sealed

end is more suitable than the open end, because it is less malleable. Slits are cut in one of the rounded surfaces of the tube with a scalpel blade. Each slit should be slightly curved and slanting, or oblique so that the thread will not slip out from it easily.

I should like to thank Mr. D. V. Kneafsey for trying the device during operations and Dr. M. Bodkin for the original drawing.

—I am, etc.,

A. MIKHAIL

Merlin Park Regional Hospital,
Galway

Size of Record Folder

SIR,—Dr. J. K. Hawkey and others (11 December, p. 667) favour the A4 folder, and their project, financed by the Department of Health and Social Security, was enhanced by a motion supporting the A4 size for general practice at the annual general meeting of the Royal College of General Practitioners on 20 November, as a reference to council.

The present M.R.E. (5 or 6) takes all sheets including quarto, or foolscap, or A4, folded once or twice only. The trouble in using it is not its size but the organization and methods of filing.

Some hospitals still fold letters to fit a window in the envelope to save typing time. This causes much unfolding and refolding when received, or none at all and stuffing in the M.R.E. as it is. There is no positive policy, such as described in the college's journal,¹ adopted by the Department of Health at executive council level, and such negative policies as there are (selective destruction, etc.) have never been published to show why the present M.R.E. was adopted in 1948, from its German original of 1910.

It needs expert attention to detail but is the right size and shape for practical politics for 50 million people.—I am, etc.,

M. J. JAMESON

St. Albans, Herts

- ¹ Jameson, M. J., *Journal of the College of General Practitioners*, 1966, 11, 336.

Sickle-cell Trait and Altitude

SIR,—The diagnosis of intestinal infarction during flight in a Ghanaian nurse with positive sickling is so important that it is surprising to find that all Dr. R. L. Green and colleagues (4 December, p. 593) could offer by way of laboratory confirmatory tests was the statement: "Haemoglobin studies later showed that she was a sickle-cell trait carrier."

I would like to record for the information of your readers that unless satisfactory answers are given by the authors to the following questions the diagnosis of "intestinal infarction in a straightforward sickle-cell trait" is at best very shaky indeed.

(1) Apart from "acute abdominal pain" and "board-like rigidity of the whole abdomen" what were the other clinical features? Was there history of cold-season rheumatism? Was the patient jaundiced or clinically anaemic?

(2) How much of A_2 , A and S haemoglobins were there? How did they exclude sickle-cell beta-thalassaemia?

(3) Was there a tendency to peculiar rouleaux formation of the red cells? What, in fact, were the haemoglobin level and platelet count? Was she polycythaemic?

(4) What about her G-6-PD? Was she deficient in this enzyme or normal?

While I wondered seriously how the three authors, who to my knowledge have never worked in Ghana, obtained such a poorly investigated case from Ghana, I recognized from the acknowledgements the name of a British surgeon who worked in the same hospital as myself. Could the authors please give further details about the patient described in Case I? Perhaps we could trace the patient and undertake a fuller investigation including a family study. This would help clear up a matter which has serious international repercussions.—I am, etc.,

R. O. ADDAE

Military Hospital,
Accra

Gastritis and L-Dopa

SIR,—Though the use of L-dopa in Parkinson's disease is now established in Britain its effectiveness is frequently limited by side effects, of which gastrointestinal disturbances are the most common. While gastrointestinal bleeding is not mentioned in most recorded series of patients on levo-dopa, Keenan's¹ report of five examples of this complication in the Eaton collaborative study of 485 cases suggests that it may be a rare sequel to L-dopa therapy. I have recently observed gastric bleeding in a patient taking this drug.

A man of 56, whose past history was unexceptional except for a myocardial infarction in 1958, developed Parkinson's disease in 1964. The disorder gradually progressed and by the time of his admission to hospital in 1970 he was severely incapacitated, and showed the typical face, voice, and posture of advanced Parkinsonism with rigidity and bradykinesia predominating. He was started on a small dose of L-dopa, which was gradually increased to 2 g a day, on which dose he was discharged together with orphenadrine which he had been taking for several years. Five weeks later he had an acute painless melaena. There was no evidence of either haemorrhage from other sites or a bleeding diathesis. Laparotomy revealed diffusely haemorrhagic and swollen gastric mucosa and a pyloroplasty was performed. The histological picture was that of a non-specific gastritis. He made an uninterrupted recovery and while continuing on orphenadrine was given amantadine in place of the levo-dopa. Five months later he died of a myocardial infarct. Postmortem examination of the stomach revealed that the previous inflammation had been replaced by diffuse mucosal scarring and submucosal fibrosis.

As acute gastritis most commonly results from extrinsic irritants, it seems reasonable to postulate that the levo-dopa may have been the cause of the bleeding in this man's case. The rarity of this complication, and its occurrence in our patient without any previous evidence of gastric disorder, suggests an idiosyncratic response as a possible mechanism.—I am, etc.,

D. RIDDOCH

Department of Neurology,
Queen Elizabeth Hospital,
Birmingham

1 Keenan, R. E., *Neurology (Minneapolis)*, 1970, 20, no. 12 pt. 2, p. 46.

Advising about Pregnancy Termination

SIR,—May I, as a family doctor of some 44 years standing and a most interested reader of "Personal View," make some comments about Dr. Andrew Smith's article (11 December, p. 678)?

The arrival in one's consulting room of a teenage girl in some distress accompanied by her mother in much more distress presages a difficult and often heart-rending interview. If termination is *not* advised what is the position some 12 months later? According to Dr. Smith, the resulting child is more likely to be rejected and become psychologically disturbed than other children.

May I quote three recent cases which go to prove the contrary? Firstly, a girl of 15; the man a soldier in Germany. Psychiatrist refused to certify. Secondly, a girl of 16; the man a West African and quite unacceptable to the girl's family. Girl refused to consider termination in spite of her mother's threats of suicide. Thirdly, a girl of 18—intending to go to university. Went to London bearing £120 in cash, accompanied by the boy friend. Both so disgusted by the conditions at a "nursing home" advertising in the medical press that she returned home on the night train and allowed the pregnancy to proceed to term.

In each of these cases the resulting baby is the apple of the mother's eye and each granny is absolutely thrilled with the child she could not even contemplate 12 months previously.

Results like these give one furiously to think, especially when it is the girl's mother who is pressing most strongly for termination.—I am, etc.,

J. D. BOTTOMLEY

Pontefract,
Yorks

Mycoplasma pneumoniae Infections

SIR,—I was fascinated to read the recent epidemiological report on *Mycoplasma pneumoniae* infections (4 December, p. 633). Unexplained, yet often striking, fluctuations in the prevalence of *M. pneumoniae* infections have been recorded amongst various populations, notably during the Parris Island (military recruit)¹ and Seattle (civilian)² studies. Indeed, a cyclic pattern of infection with a four to five year periodicity has been suggested.³ It is of interest to note that at the Brompton Hospital the incidence of *Mycoplasma pneumoniae* fell from 9% in 1968 to 7% in 1969 and only 3% in 1970, but that the number of cases diagnosed in the second half of 1971 has risen sharply.⁴

Also, whereas 18% of healthy adults living in South London had raised complement fixing antibody to *M. pneumoniae* prior to 1968,⁵ only 13% did so in 1968, 5% in 1969, and 2% in 1970.⁴ Peak antibody levels were found in the age group 21 to 40 years. It would thus appear that there has been a steady decline in the frequency of *M. pneumoniae* infection in Britain over the past four years, and that this trend has now reversed quite suddenly and for no apparent reason.—I am, etc.,

M. C. JONES

Queen Mary's Hospital,
London S.W.15

1 Chanock, R. M., et al., *Annals of the New York Academy of Sciences*, 1967, 143, 484.

2 Foy, H. M., Kenny, G. E., McMahan, R., Mansy, A. M., and Grayston, J. T., *Journal of the American Medical Association*, 1970, 214, 1666.

3 Evans, A. S., and Brobst, M., *New England Journal of Medicine*, 1961, 265, 401.

4 Personal observation.

5 Lambert, H., *Journal of Hygiene*, 1968, 66, 185.

Library for University of Hanoi

SIR,—I am helping to maintain a reference library of Western medical scientific literature in the Medical Faculty of Hanoi University, North Vietnam.

This work has helped to establish a much valued facility which is used intensively for teaching and research. May I appeal to your readers through the courtesy of your columns for contributions of books and journals? I shall be happy to arrange collection, if required.—I am, etc.,

PHILIP HARVEY

St. Stephen's Hospital,
London S.W.10

Unfair Pressure for Abortion

SIR,—Professor H. C. McLaren (11 December, p. 683) is incorrect in his belief that the M.P.U. has already given evidence to the Lane committee. It has in fact published the report of a working party on termination in *Medical World* for discussion.¹ If Professor McLaren or anyone else who does not get *Medical World* would like a copy and will write to me, I will send them one, so they can see what we really said. The next issue will contain four pages of letters on this question.

We are of course aware that some Roman Catholic doctors are opposed to termination under all circumstances on religious grounds. However, many Roman Catholic doctors and nurses resolutely refuse to allow their personal, philosophical, or religious opinions to interfere with their assessment of what is best for the patient—and what she wants.

The law as it stands permits termination with the well-known provisos. However, it is reported to us that in some areas it is extremely difficult for patients to find general practitioners and gynaecologists prepared to arrange for a perfectly legal termination, whatever the grounds. If half the terminations are at present carried out in the private sector, almost certainly many of these could have been done in the N.H.S. in some areas. No one knows how many, because the information is not recorded.

We have proposed that doctors should notify the authorities when they do *not* recommend termination on whatever

grounds simply to enable the health services to know what they need to do to meet the demand for the perfectly legal operation of termination under the N.H.S. Surely it is better for the Department of Health to know where such services are seriously deficient from the doctors themselves, rather than from other sources.

We of course agree that it is unfair that those who have the money can secure a termination virtually on demand, and our full proposals are directed to avoiding the need for the private sector.—I am, etc.,

HUGH FAULKNER

Medical Secretary,
Medical Practitioners' Union

London N.W.1

1 *Medical World*, December 1971, p. 6.

Calculation of Pension

SIR,—As matters stand pension rights for any years served in less than maximum part-time employment in hospital practice are calculated on a basis of 1½% of actual earnings. Ever-mounting inflation means that for earlier years this method yields a very much smaller pension than the adjusted eightieths method used for the whole-time and maximum part-time staff.

The argument that the calculation for a contributory pension must be based on actual earnings is quite untenable. Indeed, it is transparently dishonest because that same argument would have to hold for whole-time and maximum part-time staff, which it does not. This discrimination appears particularly mean and dishonorable when it is realized that some of us on changing to part-time practice had written into our new eight-session contracts that we were supposed to continue to do as much hospital work as when full time. This victimization of a small section of hospital doctors should be firmly opposed by the B.M.A.—I am, etc.,

DOUGLAS NEEDHAM

Aberdeen

"Added Years"

SIR,—With reference to Sir Keith Joseph's reply to the proposals for improving doctors' superannuation in the National Health Service (*Supplement*, 27 November, p. 51), Sir Keith mentions that some form of "added years" might be considered.

You may not be aware of a practice which has existed for medical staff under local government authorities in the Republic of Ireland, that the Minister for Health has the authority to grant added years service for pension purposes to professional persons joining the Health Service up to a total of 10 years, which, as far as I know, has always been granted.

This, in some way, would compensate for the late entry of doctors into the National Health Service when it is realized that no-one is entitled to a full pension who retires prior to 1988. I am sure that some arrangement could, in a similar manner, be worked out for general practitioners.—I am, etc.,

F. M. LANIGAN-O'KEEFE

Coventry and Warwickshire Hospital,
Coventry