measurable improvement in the use of contraception. These three observations answer many of the questions posed in your leading article.—I am, etc.,

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- 1 Wynn, M., and Wynn, A., *Some Consequences of Induced Abortion to Children Born Subsequently*. London, Foundation for Education and Research in Childbearing, 1973.
- 2 Matsunaga, E., *Journal of the American Medical Association*, 1966, **198**, 533.
- 3 Perinatalis Halalozas. Budapest, Kozponti Statistikal Hivatal, 1972.
- 4 Lewis, S. C., Lal, S., Branch, B., and Beard, R. W., *British Medical Journal*, 1971, **4**, 606.
- 5 Sawazaki, C., and Tanaka, S., in *Harmful Effects of Induced Abortion*. Y. Koya. Tokyo, Sanshu Printing Industry, 1966.
- 6 Beric, B. M., and Kupresanin, M., *Lancet*, 1971, **2**, 619.
- 7 Tietze, C., *Family Planning Perspectives*, 1973, **5**, 38.

SIR,—In discussing the Wynns' report¹ on the consequences of induced abortion you comment (3 March, p. 506) that "in Britain notifications of abortion include only the complications occurring in the first week—much too short a period on which to base estimates of morbidity, especially when in the private sector patients are frequently seen only for one day."

That is certainly so, and it may be worth pointing out that the same applies for deaths after legal abortions. The Secretary of State for Social Services recently admitted² that "in addition [to notified deaths] some deaths are attributed to abortion although not shown on the abortion notification; this number is not yet available for 1972 but there were 2 in 1971, 1 in 1970, 2 in 1969 and 1 in 1968," as recorded on death certificates. Presumably these patients died after the form required under the Abortion Regulations had been sent in to the D.H.S.S. This answer corrected some figures previously given³ which had not included un-notified deaths, and it is now agreed that at least 20 women died within one month of legal abortions in 1969, including one un-notified suicide three weeks after the operation, but not "attributed to abortion," mentioned on p. 92 of the "Report on Confidential Enquiries into Maternal Deaths in England and Wales, 1967-1969."⁴ And there is no certainty that there may not have been other un-notified deaths attributed to causes other than abortion, which themselves were more or less directly due to the legal abortion operation.

It is a matter for some concern that the "Confidential Enquiries" report (table 5.2, p. 40) shows that only 12 deaths after legal abortions in 1969 were investigated, this being the only full year under the new law for which information is as yet available; this represents 60% of the 20 known deaths, themselves not necessarily complete. That compares unfavourably with the "89% of the deaths known to the Registrar General being reported on" (p. 9 of the report) for maternal deaths from all causes and suggests that the rules for notifying deaths after legal abortions ought to be tightened up. Would it, for example, be possible to require that all "approved places" should report any deaths occurring within three months of legal abortions to the D.H.S.S., whether or not the notification form had been sent in, and that full details of every such death should be made available for investigation under the

"Confidential Enquiries" procedure?—I am, etc.,

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- 1 Wynn, M., and Wynn, A., *Some Consequences of Induced Abortion to Children Born Subsequently*. London, Foundation for Education and Research in Childbearing, 1973.
- 2 Hansard, House of Commons, 6 February 1973, Written Answers, col. 69. London, H.M.S.O. (See also *British Medical Journal Supplement*, 17 February, p. 430.)
- 3 Hansard, House of Commons, 12 December 1972, Written Answers, col. 69. London, H.M.S.O. (See also *British Medical Journal Supplement*, 23 December, p. 742.)
- 4 Department of Health and Social Security, *Report on Confidential Enquiries into Maternal Deaths in England and Wales, 1967-1969*. London, H.M.S.O., 1972.

Fetal Rights and Abortion Laws

SIR,—A leading article (27 January, p. 191) and your medicolegal expert (p. 244) both record that the Law Commission has expressed its provisional view that a child with injury or deformity caused by somebody's negligence before birth could sue that person for damages. The same principle is being supported in the course of the thalidomide case and it is a principle with which nobody can seriously disagree.

When one looks at it, however, in the context of the present abortion laws, it is clear that either this principle or the abortion laws must be wrong. According to the abortion laws a fetus has no separate existence apart from its mother and in certain circumstances can be killed. If this "thing" which has not and never had an existence of its own also has no legal right to live, how can it have legal rights of any kind?—I am, etc.,

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Acute Appendicitis and Salmonella Infections

SIR,—In his article on salmonella infections (13 January, p. 98) Dr. A. M. Geddes rightly states that in some instances the severity of the abdominal pain can lead to the patient being referred to a surgeon. It is perhaps worth recording eight such cases in the Reading area between November 1967 and April 1970. Stool cultures were positive for the following organisms: *Salmonella typhimurium* (4), *S. enteritidis* (2), and *S. paratyphi B* (1). *S. panama* was isolated from the infected abdominal wound of another patient. In addition, *Shigella sonnei* was isolated from the stools of eight more patients with similar symptoms during the same period. Appendicectomy was performed on 12 of these 16 patients—one appendix appeared normal at operation, four were mildly inflamed, five showed acute inflammation, and two had perforated.

The true incidence of appendicitis associated with salmonella and shigella infections of the bowel is not known but is probably higher than is generally realized. Rubenstein and Johnson¹ and White *et al.*² have previously drawn attention to this condition, and stressed that a stool culture positive for salmonella or shigella does not necessarily contraindicate appendicectomy should the clinical signs suggest the presence of acute appendicitis. Nor can much reliance be placed upon the white blood cell count or

the degree of pyrexia in making a diagnosis. In the present series one patient with sonne dysentery had on admission a temperature of 101.2°F (38.4°C) with a W.B.C. of 21,000/mm³ yet recovered without the need for operation, and in the group with acutely inflamed or perforated appendices the W.B.C. did not exceed 16,000/mm³—in most instances it was below 10,000 and in only two patients did the temperature exceed 101°F (38.3°C). Some of these latter patients had received antibiotics before admission, which perhaps indirectly affected their pyrexia and W.B.C. As might be expected, six of the seven patients with acutely inflamed or perforated appendices were aged between 6 and 12 years, but one was aged 37. Five of these were infected with *Sh. sonnei* and two with *S. typhimurium* and *S. enteritidis* respectively.

It is clearly unwise to dismiss symptoms and signs of acute appendicitis as being of little significance in the presence of positive stool cultures and, in the words of Bailey and Love,³ "it is better to look and see than to wait and see."

I am grateful to the consultant physicians and surgeons at the Reading group of hospitals for providing the clinical details of their patients. —I am, etc.,

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- 1 Rubenstein, A. D., and Johnson, B. B., *American Journal of the Medical Sciences*, 1945, **210**, 517.
- 2 White, M. E. B., Lord, M. D., and Rogers, K. B., *Archives of Disease in Childhood*, 1961, **36**, 394.
- 3 Bailey, H., and Love, M., *Short Practice of Surgery*, 15th edition, ed. A. J. H. Rains and W. M. Capper, p. 982. London, H. K. Lewis, 1971.

Nature of Hyperacute Rejection

SIR,—Mr. A. H. Amery and others (24 February, p. 455) do well to refer to hyperacute rejection as second set rejection. Hyperacute rejection is a confusing and quite a dangerous term to use clinically unless one has been prepared experimentally for early posttransplant anuria.¹ Though one can commiserate with immunologists² who are unable to handle orthotopic skin grafting, it is sad, if not surprising, to find a surgical team resorting to subcutaneous skin grafts. Orthotopic autografting and allografting of skin is still a worthwhile surgical exercise and should always be performed together as a control of technique. From a biological standpoint also it may be learned that "cells" are often as numerous in autografts as in allografts of skin and also that the second set skin allograft rejection process is a dull affair compared with the immediate high drama of the kidney second set allotransplant. It is interesting also to note that Mr. Amery and his colleagues used skin as the sensitizing tissue and not the miraculous lymphocytes. It was because I was quite unable to sensitize with lymphocytes by any or all routes simultaneously that I resorted to skin grafting,³ but recent authors inventing such techniques⁴⁻⁶ seem unaware of my report.

After a fair investigation of the natural history of the second set kidney allotransplant I honestly do not know what causes the intense vasoconstriction, which is the only factor common to the rejection of all kidneys I have observed. This, apparently, is heresy to those immunologists anxious to