objective criteria, however crude, to bear on a clinical situation which, at the moment, is not apparently governed by any clear guidelines. We anticipate that these criteria will be refined or perhaps replaced as evidence from other centres (supported by results) becomes available.—We are, etc.,

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Working of the Abortion Act

SIR,—In carrying out a survey for quite different purposes, over 600 doctors have replied to a questionnaire which included a request for their views on the present Abortion Act. These doctors are all general practitioners holding the postgraduate diploma of the Royal College of Obstetricians and Gynaecologists and have a median age of 36 years. They are likely therefore to be doctors of first contact to a considerable proportion of the unwanted pregnancies in their practices.

Sixty per cent of these doctors thought that the present Abortion Act was a reasonable compromise, 22% that it was a major social advance, and only 14% that it was a tragic mistake. The other 4% gave less easily classified answers. A survey of over 200 rural practitioners gave almost identical results.

Policy-making by referendum may not be wholly without its little difficulties; but these figures were thought to be of sufficient general interest to warrant separate publication.—I am, etc.,

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SIR,—There has recently been much defence by doctors of their freedom to undertake private practice and receive a fair reward for work done. In contrast, these columns have seen little reaction to the Abortion (Amendment) Bill which, however, disguises a much greater threat to the freedom of doctors and of women. This Bill is now being considered by a select committee whose members were chosen two-to-one in favour of its acceptance.

Ostensibly designed to end the rare but regrettable exploitation of women under the present Act, the Bill is also attracting the support of some who are committed to the abolition of private practice or who are influenced by its clause concerning the use of fetal tissue. However, little publicity has been given to its removal from the present law of the invaluable yardstick for comparison—namely, that of the damage that would result were the pregnancy to continue to term. This, along with the insertion of two adjectives, "grave" and "severe," will make interpretation of the proposed law impossible.

Further, the onus is to be on the doctor to prove his innocence, in complete contravention of the principles of British law. It is conceded that this is a throw-away clause; the effects of the Bill will none the less remain essentially unchanged when, as is in-

evitable, this clause is removed to pacify opposition. These effects would be grossly to reduce the (still inadequate) possibility of having an unwanted pregnancy terminated and thus of causing the unwelcome resurgence of back-street abortionists.

In this International Women's Rights Year the attempted denial by this Bill of the right of women to equality through the control of their own fertility, and its restriction of the freedom of their doctors to offer them whatever treatment is in their best interests, is a threat that must be met by a much more determined protest than has yet appeared.—We are, etc.,

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** Though this Bill has been given a second reading in the House of Commons its reference to a select committee provides the opportunity for interested persons and bodies outside Parliament to make known their views before any decision is made on the further progress, if any, of the Bill, and the committee has invited them to do so. The B.M.A. has already submitted written evidence and has asked to be allowed to give oral evidence as well. Other organizations or individuals wishing to submit memoranda should send them to the Clerk to the Committee on the Abortion (Amendment) Bill, House of Commons, London S.W.1.—Ed., B.M.J.

Iron Treatment of Dialysis Patients

SIR,—The drawbacks of regular intravenous iron therapy to patients undergoing regular haemodialysis treatment are clearly presented by Dr. S. Hussein and his colleagues (8 March, p. 546). Their emphasis on monitoring the exact amount of iron therapy needed is justified by the increased marrow iron stores of most of their patients. What is not so clear is how their data allow this dose to be calculated and overloading avoided.

Since there is no good evidence to suggest that oral iron is less effective than intravenous iron in patients on regular haemodialysis, nor that it can overload marrow iron stores, a safe alternative is to give oral iron to all these patients. In contrast to Dr. Hussein and his colleagues we have found a significant correlation between transferrin saturation and marrow iron. Rises in haemoglobin level with oral iron are significantly greater when transferrin saturation is below 30%.¹ Transferrin saturation thus provides a simple indication of the likely response of patients treated with oral iron; it may not reflect iron overload, but this has not proved a problem if the parenteral route is avoided.—We are, etc.,

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¹ Strickland, I. D., et al., *Clinical Nephrology*, 1974, 2, 13.

Treatment of Paracetamol Poisoning

SIR,—Your otherwise informative leading article on paracetamol poisoning (8 March, p. 536) states that "biochemical treatment will therefore need to be restricted to the first 48 hours after ingestion of the paracetamol." However, there is no evidence that the only proved effective antidote in man, cysteamine, is effective after 12 hours.¹ In fact, patients with induced liver microsomal enzyme systems are particularly prone to damage² and in one such patient, who was an alcoholic, treatment nine hours after gross overdosage was only partially successful.³

Hepatic damage seems to be irreversible by these means 12 hours after overdosage and treatment at this stage with any compound that is largely taken up and metabolized by the liver is potentially dangerous. In our experience of one patient so treated there was a transient fall in level of consciousness.

If a controlled trial is thought to be justifiable,⁴ then only those patients treated within 12 hours of overdosage should be compared with untreated subjects.—We are, etc.,

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¹ Prescott, L. F., et al., *Lancet*, 1974, 1, 588.

² Wright, N., and Prescott, L. F., *Scottish Medical Journal*, 1973, 18, 56.

³ Scott, C. R., and Stewart, M. J., *Lancet*, 1975, 1, 452.

⁴ Gazzard, G. B., et al., *Lancet*, 1974, 1, 864.

Practolol and Sclerosing Peritonitis

SIR,—In their article on "Fibrinous Peritonitis: A Complication of Practolol Therapy" Mr. W. O. Windsor and his colleagues (12 April, p. 68) observe that immediate withdrawal of practolol may result in resolution of the condition.

We have recently observed a similar case of fibrosing peritonitis which presented with intestinal obstruction one year after cessation of practolol therapy. At laparotomy this patient, a man of 66, showed the characteristic fibrous membrane enclosing the small bowel, with thickening of both visceral and parietal peritoneum, and the histological features were similar to those described as "sclerosing peritonitis" by Brown et al.¹ Special stains and all routine investigations were non-contributory. However, it emerged that the patient had had a psoriasisform rash while on practolol therapy, this being the reason for its withdrawal. The patient subsequently died from rupture of a traction diverticulum of the caecum, produced by the peritoneal adhesions, four weeks after laparotomy.

Of the cases of practolol-associated sclerosing peritonitis recently reported, two occurred eight months after stopping practolol^{1,2} and another one, like our case, presented 12 months after practolol had been discontinued.³ All the patients appear to have received the drug for over one year.

We would like to emphasize that withdrawal of practolol does not necessarily protect the patient from sclerosing peritonitis and that it is therefore worth checking the