CORRESPONDENCE

Prostaglandin-induced Abortion and Cervical Incompetence M. P. Embrey, F.R.C.O.G. 497	Complications of Laparoscopy P. Rhodes, F.R.C.O.G. 501	Women Doctors Jean Ginsburg, D.M. 503
Risks of Total Hip Replacement J. Charnley, F.R.C.S., F.R.S. 498	Side Effects of Methyldopa W. D. Alexander, M.R.C.P., and J. I. Evans, M.B. 501	Consultant Negotiations F. E. Weale, F.R.C.S.; J. H. E. Bergin, M.B.; L. D. Abrams, F.R.C.S., and others 504
Safer Cigarettes Sir George Godber, F.R.C.P. 498	Hospital Pharmacy Committees M. S. Knapp, M.D. 501	Qualifications of Trainers M. J. Scurr, M.B., and D. M. Wilks, M.B. 504
Beta-blockers and Fibrinous Peritonitis J. F. Gurry, F.R.C.S., and others 498	Social Work in General Practice G. Keele, M.R.C.G.P. 501	Seniority Payments M. H. Russell, M.B. 504
¹²⁵I-Fibrinogen Test in Diagnosis of Deep Vein Thrombosis C. V. Ruckley, F.R.C.S.ED. 498	Prescribing Barbiturates P. S. Boffa, M.D. 502	Review Body Award and Medical Assistants I. M. Librach, M.B. 504
Malaria Vaccines L. J. Bruce-Chwatt, F.R.C.P. 499	Long-acting Phenothiazines J. A. Whitehead, M.R.C.PSYCH. 502	Enough is Enough? Hazel M. Rawlinson, M.R.C.O.G. 504
Prophylaxis against Deep Vein Thrombosis L. T. Cotton, F.R.C.S., and V. C. Roberts, PH.D. 499	S.I. Units G. H. Hall, F.R.C.P. 502	Review Body Award and the Cameron Fund P. J. Bryce-Curtis, M.R.C.S. 505
Fetal Damage from Breech Birth W. D. Griffiths, F.R.C.S.; P. R. B. Pedlow, F.R.C.S.ED. 500	Drugs for Common Cancers G. A. Edelstyn, F.R.C.R., and others 502	Points from Letters Erythema Infectiosum (Joyce K. Tweedie); Drug Combinations for Anaesthesia (J. P. Alexander); Imported Sterile Water (D. N. H. Hamilton); Rats Today (M. R. Hadler); Illness in the Clouds (N. C. Lee); Morrison Report (Susan Holliday); Cerebral Vasodilators (W. P. MacLay); Fees for Insurance Reports (E. B. Allen) 505
Warfarin Poisoning in Domestic Animals S. M. Crispin, M.R.C.V.S., and others 500	Fibre Content of Bread C. L. Copeland 503	
Diffuse Pulmonary Disorder Caused by Oxyphenbutazone D. C. Cameron, M.R.C.P. 500	Dangers of Humidification of Inspired Air R. C. Browne, F.R.C.P. 503	
	Prevention of Overdoses P. M. Vicary, M.B. 503	
	Basic Science and Specialist Registration S. R. Wealthall, M.B. 503	

Correspondents are urged to write briefly so that readers may be offered as wide a selection of letters as possible. So many are now being received that the omission of some is inevitable. Letters should be signed personally by all their authors.

Prostaglandin-induced Abortion and Cervical Incompetence

SIR,—While the efficacy and relative safety of the method is increasingly accepted, some prominence has been given in recent months to the occurrence of cervicovaginal fistulae as a consequence of prostaglandin-induced midtrimester abortion. A recent communication by Murray¹ has highlighted another complication affecting the cervix which may result from a midtrimester abortion induced with prostaglandins—cervical incompetence in subsequent pregnancies. In view of this report it seems timely to record data relating to patients who have become pregnant following a previous prostaglandin-induced midtrimester abortion in this unit.

Among 307 patients followed up for 18 months or more after prostaglandin termina-

tion, 53 pregnancies have occurred in 46 patients; these include 27 term deliveries (with one stillbirth of unspecified gestation and aetiology), three pregnancies as yet undelivered, 13 repeat therapeutic abortions, eight spontaneous abortions, and one ectopic pregnancy.

The eight spontaneous abortions are analysed in the table. Of the five spontaneous first-trimester abortions, each has been followed by an uncomplicated full-term delivery. Of the three spontaneous second-trimester abortions, each was an unplanned pregnancy and none has been followed by a further pregnancy. In one of the latter there was clinical evidence suggestive of cervical incompetence, but it may be significant that

in this case vaginal aspiration termination of a 14-weeks' gestation preceded the pregnancy terminated by prostaglandins and, further, the prostaglandin induction/abortion interval was unusually short (3½ hours).

Of the 26 fully documented full-term pregnancies, the mean gestation at the time of spontaneous labour (16 cases) was 40·2 weeks (range 37–42 weeks) and the mean duration of labour in all 26 cases was 9·7 hours (range 2–32 hours). No neonatal complications were encountered.

The implication of Murray's report is that the risk of subsequent cervical incompetence is particularly high following the intra-amniotic administration of prostaglandin F_{2α}. However, the presumption may not be justified, for the intra-amniotic route has been that most widely employed for second-trimester abortion, while PGF_{2α} has been used more frequently than PGE₂ because it is more readily available.

That there is some risk of subsequent incompetence of the cervix in any mid-trimester abortion is accepted, but the risk is proportional to the degree of cervical trauma, and evidence of cervical incompetence occurring probably as a result of first-trimester vaginal termination has been documented.² The suggestion made by Murray of routine encirclage in subsequent pregnancy for all patients with a history of previous prostaglandin-induced abortion would, on the evidence at present available, seem unduly radical and not warranted.—I am, etc.,

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Eight Spontaneous Abortions after Previous Prostaglandin-induced Abortion

Patient	Parity	Gestation at Abortion (weeks)	Prostaglandin Used and Route of Administration	Prostaglandin Induction/Abortion Interval (hours)	Gestation at Spontaneous Abortion (weeks)	Comments
1	0 + 0	18	E ₂ E.A.	10	8	Subsequent uncomplicated term pregnancy
2	1 + 0	16	F _{2α} I.V.	11½	7	" " "
3	0 + 0	14	E ₂ E.A.	10	8	" " "
4	3 + 0	22	F _{2α} E.A.	22	8	" " "
5	0 + 0	18	E ₂ E.A.	18½	11	Subsequent ectopic pregnancy followed by term pregnancy
6	5 + 0	16	F _{2α} E.A.	37½	22	—
7	0 + 1*	16	E ₂ E.A.	3½	23	Clinical evidence of cervical incompetence
8	0 + 0	18	F _{2α} I.A.	27	24	—

*Previous 14-week termination by vaginal aspiration. E.A. = extra-amniotic. I.A. = intra-amniotic. I.V. = intravenous.

1 Murray, J., *Medical Journal of Australia*, 1972, 2, 717.
2 Wright, C. S. W., Campbell, S., and Beasley, V., *Lancet*, 1972, 1, 1278.