tumour, and this was significantly different (χ^2 with Yates's correction = 11.18, $P < 0.001$) from histopathologically reactive patients. Though it is too soon to assess our results in terms of patients' survival, we would like to suggest that histopathological analysis of tumour and lymph nodes might provide an alternative when skin testing is not feasible. —We are, etc.,

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Prostaglandins and Asthma

SIR,—I read the paper by Dr. K. R. Patel (17 May, p. 360) on the effects of possible antagonists on $\text{PGF}_{2\alpha}$ -induced bronchoconstriction with interest; he confirms previous reports¹⁻³ on the effect of this prostaglandin and the failure of disodium cromoglycate to inhibit it.³ As atropine does not inhibit the effect of $\text{PGF}_{2\alpha}$ in normal subjects^{1,3} it appears to have a direct action on the bronchus, but the response in asthmatics, whose sensitivity varies between 9300 and 10 times more than normal,³ is partially inhibited by anticholinergic drugs such as atropine and ipatropium bromide (Sch 1000).⁴ Patients with asthma are known to react adversely to irritant inhalants,⁵ to which we have always attributed the exaggerated response of asthmatics to $\text{PGF}_{2\alpha}$.

Dr. Patel's statement that PGE_2 is a less potent bronchodilator than isoprenaline is not supported by any data, which is a pity, as it is at variance with other published reports.⁶ To draw such conclusions it is necessary to construct dose-response curves to the two drugs and to calculate the dose ratio. Such an experiment, to be published, shows that in man PGE_2 (when it causes bronchodilatation) and isoprenaline are approximately equipotent. Several of our patients have developed bronchoconstriction as a result of inhaling PGE_2 , an observation also made by others,² which was not prevented by atropine, suggesting a pharmacological rather than an irritant response. The bronchospasm that occurs in about half the subjects receiving it by the intravenous route^{7,8} may be due to an active metabolite.

As the mixture of E- and F-series prostaglandins, in a ratio of 6:1,⁹ released during anaphylaxis would tend to inhibit the development of bronchospasm, and because of the failure of indomethacin to affect day-to-day asthma or challenge by exercise or antigen,¹⁰ it seems unlikely that the parent prostaglandins contribute to the pathogenesis of asthma. It may be that their metabolites are more important, but the wide variety of factors leading to prostaglandin release by the lungs suggests that they represent a non-specific response. The latter may have

important autoregulatory functions.—I am, etc.,

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Cost of Going Metric

SIR,—The recent comments regarding SI units by Mr. B. H. Hand and others (17 May, p. 389) call for a resurvey of the equally unnecessary transfer of x-ray film sizes from imperial to metric standards. In a district serving 250 000 people but considerably underprivileged financially it cost £4000 to replace the cassettes, hangers, etc.

The simplest illustration of the consequent increased running costs is in chest radiography. In the past almost all female and perhaps 15% of male chests could be taken on a 15×12-in film; the metric substitute, 30×40 cm is longer but thinner and can only rarely be used. Thus the larger 35×43-cm or sometimes the 35×35-cm film has to be employed, the former being a 32% and the latter a 9% increase in emulsion area. The following figures are only approximate, having been obtained by sampling. It is doubtful if a more accurate assessment could be made.

Total P.A. chest films annually in District	20 000
50% of patients needing larger film	
Half at 9% increase	
Half at 32% increase	1950
(whole film equivalents)	

Assuming an equal population usage the national annual increase is approximately 400 000 film equivalents at a cost (this week) of £164 000. This is only one single common but cheap type of examination and can be matched in almost every field of radiography. The imperial standards happened to be ideally matched to their task and the American continent, probably the largest user, has no intention of being inveigled into a change that can be of advantage only to a minority.

As the world supply of silver at the rate of present usage will probably last less than 20 years and x-ray film is one of its most wasteful users, in conservation terms the transfer was not simple stupidity but criminal folly.—I am, etc.,

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Abortion (Amendment) Bill

SIR,—On reading your extraordinary leading article (17 May, p. 352) opposing the tightening of the Abortion Act, I re-read the original 1967 Act in search of the words "entitled to abortion." There is no such phrase in the Act, nor a hint that a request for an abortion is ipso facto an indication

for an operation. You quote the Lane Committee as stressing that to advise against an abortion urgently requested is unfeeling, implying that to accede is kind—to the mother, but not of course to the unborn son or daughter. I take it that you would suggest the obverse. A doctor, after all, receives a patient seeking an abortion as a patient (patior=to suffer). He receives her with compassion, and when the facts are established he offers not necessarily an operation (easily bought in private State-licensed abortoria) but his *opinion* as to what is best for both patients now and in the future. The opinion of a colleague may or may not agree, but a second opinion is obligatory.

Mr. White proposes the amendment of section 1(1)(a) of the 1967 Abortion Act to read "that the continuance of the pregnancy would involve: (i) *grave* risk to the life of the pregnant woman; or (ii) risk of *serious* injury to the physical or mental health of the pregnant woman or any existing children of her family," and of section 1(3) to make it necessary that a consultant (not yet defined) should be on the staff of all places licensed to carry out abortions. I see such additions as a great clarification and a help to the family doctor who may be in a quandary when presented with an abortion request.

I heard Parliament debate Mr. White's amending Bill 12 weeks ago. Obviously our M.P.s have been shocked at the rackets, touts, and agencies which were inevitable when in 1967 their predecessors agreed to "nursing home" abortions (section 1(3)) without proper supervision or control. No M.P. suggested, however, that abortion on demand—the code of private abortion practice—should be transferred, with its special morality, to N.H.S. hospital practice. If, however, the State does decide to limit abortions to the N.H.S., first of all it must persuade willing doctors and nurses to carry out abortion on demand and chiefly for socioeconomic indications. Then the State must also finance the service (for an abortionist should be well paid) but not by cutting into the funds available for the care of other deserving patients. Any attempt to graft what I regard as illegal abortion on demand on to modern gynaecological or obstetric practice I believe will fail, and not only on moral grounds but also on aesthetic grounds. Despite constant pressure I believe that very few doctors or nurses believe that abortion on demand is either good medicine or acceptable ethics.—I am, etc.,

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Safer Cigarettes

SIR,—In the title of your leading article "Safer Cigarettes" (17 May, p. 354) you are helping to promote the idea, fondly encouraged by the tobacco industry, that cigarettes containing synthetic materials are "safer," or even "safe." Surely "Less Lethal Cigarettes" would have been more accurate? And it will be many years before the question mark could be removed. Though these new cigarettes may be less carcinogenic, synthetic materials produce just as much carbon monoxide as tobacco. Carbon monoxide is probably the most important