tumour, and this was significantly different (χ^2 with Yates's correction $=11{\cdot}18$, $P<0{\cdot}001$) 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 $PGF_{2\alpha}$-induced bronchoconstriction with interest; he confirms previous reports[1-3] on the effect of this prostaglandin and the failure of disodium cromoglycate to inhibit it.[3] As atropine does not inhibit the effect of $PFG_{2\alpha}$ 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 $PGF_{2\alpha}$.

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 variey 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 underpriviliged 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

cause of cardiovascular disease, which accounts for about half the excess mortality from smoking.

You state that there is little substantial decline in either cigarette sales or the number of people who smoke, yet you do not point out the dramatic fall of cigarette smoking in doctors, in other members of social class 1, and in class 2, especially among men. You refer to the impossible goal of stopping smoking by health education programmes, yet after the first of the two recent Thames Television programmes, "Dying for a Fag," it was estimated that about 160 000 people stopped smoking at least temporarily, and this represents about 2% of the smoking population. The fact that the tobacco industry is putting some of their workers on short time illustrates that the fall in tobacco sales which followed the recent tax increase is expected to last. It would have been more appropriate if, instead of decrying health education you had followed the B.M.A. Council's recommendation[1] in relation to smoking that "more attention should be paid to the way in which information is disseminated and attitudes are formed and an evaluation made of the methods used."

It is conceivable that in 20 years there may be evidence to show that cigarettes which include synthetic materials are indeed safer. Until this time arrives we strongly deplore the use of the term "safer cigarettes," though we agree that efforts to investigate forms of smoking which may be less lethal should be encouraged.

Doctors should give patients the same advice to stop smoking which they themselves have accepted and which has been such an important cause of the reduction in mortality from both lung cancer and coronary heart disease in the medical profession.—We are, etc.,

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1 *British Medical Journal Supplement*, 1971, 2, 91.

Better Medical Writing

SIR,—Dr. J. S. Bradshaw (26 April, p. 194) is confusing three different things: the techniques of medical writing, the correct use of the English language, and literature.

Medical writing—at least in its most important branch, that which deals with reports of original research as distinct from didactic or review articles—has no connexion with the kind of literary writing to which Dr. Bradshaw refers. It is a technique whose principles and practices are applicable whatever the language used. If the language used happens to be English of course it is best for it to be good English, but above all it should be plain and simple English, because the world's research workers do not read English with ease. Work reported in the style of T. S. Eliot, Swift, or Sir Thomas Browne, as Dr. Bradshaw recommends, would be liable to be ignored in the research laboratories of Moscow and Peking, or even in those of Baltimore or San Francisco.

Giving scientific papers a standard formal structure has solid advantages, and these have been ably analysed elsewhere.[1 2] It is comparable to writing hospital case-notes according to a uniform pattern. Both these practices make for orderly thinking by the writer and easy assimilation by the reader. But neither research reports nor case-notes are literature. Case-notes, incidentally, and written examinations are the first branches of medical writing that we meet in our medical career, and this is one of many reasons why notions of medical writing should be taught at an early stage. To say that undergraduates should not be taught the elements of medical writing because they already know (or should know) how to write would be analogous to saying that they need not be taught the elements of medical statistics because they already know (or should know) how to count.

The book[3] which Dr. Bradshaw inaccurately calls a "pedagogic 'core' course" is, as its name indicates, intended specifically as a guide for those who want to write papers in English. Therefore, naturally, it deals with both (1) the principles of scientific writing and (2) the correct use of English in scientific writing. But the principles of scientific writing that it outlines are applicable to writing in any language.

Some authorities believe that eventually all "important" research will be reported in English, other languages being used only for papers of purely national interest. This may be true for countries whose languages practically no one else understands. But for France, the cultural leader of a huge francophone community, it is neither desirable nor necessary. Unfortunately, some French medical writers scorn, like Dr. Bradshaw, modern medical writing techniques and regard the use of the French language as necessarily linked with literary writing, thereby lowering the credibility of their country's medical literature and preventing their country's research from receiving the international recognition it deserves. According to an eminent French surgeon,[4] ambitious young surgeons in France do not take French medical publications seriously and some French official scientific bodies do not recognize papers published in French journals. Happily, we have watchful medical editors to protect our British journals from ideas like Dr. Bradshaw's.—I am, etc.,

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SIR,—I enjoyed your leading article "Better Medical Writing" (12 April, p. 56) and look forward to the publication of the seminar on "Speaking and Writing in Medicine" that is scheduled for this autumn. It is a pity that more American medical writers cannot avail themselves of this learning experience. As one who has spent an entire professional career in medical communication, I am frequently chagrined by the general low calibre of English language usage by medical writers on this side of the Atlantic. All too frequently the results of excellent clinical investigations are rejected for publication simply because the authors are incapable of expressing themselves in clear and coherent English prose. On the other hand, all of us have noted the consistently higher quality of medical writing by our British colleagues. This is why the *B.M.J.* is such a joy to read.—I am, etc.,

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Injudicious First-aid

SIR,—I have followed with considerable interest the recent correspondence on injudicious first-aid. There seems little doubt that it is essential for personnel trained in first-aid to attempt resuscitation when it is indicated. The problem lies in the poor standard of the training given. As a corps surgeon in the St. John Ambulance Brigade, I examine in first-aid very often and am highly critical of the average standard of performance in resuscitation. It is often too painfully obvious that the candidate is trying to carry out from memory a mechanical operation read in the manual, without any idea whatsoever of the physiological principles which lie behind what he is doing. This leads to some quite remarkable performances. In my view no first-aid certificate should be granted until the candidate shows clearly that he understands not only the practice but the principles of resuscitation. This is not met by a few puffs into a resuscitation model.

I fear the blame for this unsatisfactory state of affairs must lie to a considerable degree with the medical profession. In my own area, and I suspect in many others, voluntary groups such as the St. John Ambulance Brigade have the greatest difficulty in recruiting doctors to do the training required. Some brigade divisions have not had a divisional surgeon for years and their attempts to interest local practitioners meet with no success. If resuscitation is worth doing, as it obviously is, then medical practitioners must be willing to co-operate with the first-aid organizations so that it is properly taught.—I am, etc.,

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Dextran 70 and Thromboembolism

SIR,—I was very interested in the paper by Mr. A. L. Kline and others on this subject (19 April, p. 109) with its encouraging clinical message. I would like, however, to ask two questions: (1) Have they any reason to believe that two bottles of dextran are any more effective than one? and (2) is it possible that the increased bleeding commented on is from an overfull vascular compartment?

Dextran 70 is hypertonic, and in the absence of bleeding a 500-ml infusion could be expected to increase the blood volume by 10-20%. My own practice is to use 500 ml of dextran 70 prophylactically but in the absence of significant blood loss to give only 250 ml during surgery and the remainder postoperatively.

I have not seen increased bleeding with this regimen that could not be explained by a combination of excess fluid and vaso-