answerable question at the moment and remains a challenge for future research.—We are, etc.,

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Myocardial Infarction and Metabolism

SIR,—In your leading article "Metabolism and Infarction" (14 September 1974, p. 643) you indicated that the extent of ischaemic damage could be altered by metabolic manoeuvres, including lowering the circulating free fatty acid concentrations, and you were kind enough to refer to the work of my group, which has now been published in preliminary form.[1] However, your article suggested that metabolic manipulation may be effective only in the first hour or two after the onset of symptoms. But experimental myocardial infarction in the dog takes a week for the full extent of necrosis to be manifest.[2] The experiments of Maroko *et al.*[3] on dogs showed that glucose, insulin, and potassium therapy could reduce infarct size even when started three hours after coronary artery ligation, and in man Shell and Sobel[4] have shown reduction in infarct size by reduction of after-load in hypertensive patients seven hours after the onset of rise of blood creatine phosphokinase—that is, probably about 12 hours from the onset of symptoms. Judged by decreased precordial ST-segment elevation, decreased ischaemic damage in man can be achieved up to 72 hours after the onset of symptoms, as shown by Shillingford's group.[5] Conversely, experimental infarcts can be aggravated up to 72 hours after coronary artery occlusion by isoprenaline infusion.[6]

It would therefore seem that metabolic manipulation may well play a role even if started hours after the onset of symptoms, and every effort should be made to encourage the testing of the effect of reduction of circulating free fatty acids and/or promotion of glucose metabolism; glucose, insulin, and potassium therapy should do both. An effect of this treatment on infarct size in man has not been found, nor has it been looked for. To assess infarct size in man is not easy. Some of the principles and problems in relation to the possible use of glucose, insulin, and potassium are outlined elsewhere.[7 8] Other metabolic possibilities include the use of dichloroacetate to help influx of pyruvate into the citrate cycle,[9] as suggested in your leading article.

Finally, it should be noted that it is increased cyclic AMP, and not AMP as stated in your article, which has been found in the blood of patients with acute myocardial infarction.[10 11] The cyclic AMP change may reflect increased catecholamine activity, which can also be monitored by plasma glycerol changes.[12]

The Chris Barnard Fund and the Medical Research Council of South Africa are thanked for support.
—I am, etc.,

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Abortion (Amendment) Bill

SIR,—Your leading article (17 May, p. 352) and the subsequent statement given on radio by the Secretary of the Association in reference to the sit-in at B.M.A. House would suggest that the Abortion (Amendment) Bill is entirely evil and contrary to the highest standards of medical practice. The report of the Lane Committee is cited in support and you would have us believe that basically all is well with the present position. All is not well, and it is exactly because it is not that the Abortion (Amendment) Bill was introduced.

The 3243 terminations of pregnancy last year in girls under the age of 16 years should not be seen as an isolated phenomenon and unconnected with the present attitude to regard abortion as a form of contraception. We are told there is another answer to that too, which is to prescribe the pill to even younger age groups so that the whole country will be eventually "protected." Yet in spite of an already considerable extension of contraception for youngsters, the abortion figures in this group continue to rise.

You object to the introduction of adjectives such as "grave" and "serious," yet these have been used in medical practice for many years and have a greater reliability of interpretation than most others. The Bill introduced by James White was intended to make doctors face up again to their responsibilities and it is sad, though in this age not too surprising, to see a distinguished journal plead that doctors should not be asked to behave responsibly.

When one considers that upwards of 90% of the 150 000 legal abortions are done on psychiatric grounds when all the evidence shows that no "grave" or "serious" psychiatric threat to the mother's health exists it is not protection that the doctors require from its leading journal but exposure. And what of those doctors who, rightly, will not abort unless the threat to the mother is "grave" or "serious"? Are you suggesting that they are less worthy medical practitioners than the abortionists?

This medical stable is filthy and if we do not clean it out ourselves we cannot complain if others will do the job for us. There are still, fortunately, many doctors in this country who support the James White Bill and it is largely under pressure from many of my colleagues who share my views that I have written this letter.—I am, etc.,

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SIR,—I am very weary of reading letters in the *B.M.J.* on sanctity and the "right of conscience" to abstain from giving medical help in abortion. How refreshing it would be to read some of real Christian concern and compassion for the woman in distress with an unwanted pregnancy and of some medical sense of responsibility in preserving her from the results of "back-street" abortion.

The fetus in the great majority of unwanted pregnancies will die anyhow. It may be by a knitting needle, a crochet hook, slippery elm-bark, or drowning in the W.C. Or if it survives so far, being overlain or let die. But it will die. It is time this nonsense of writing and talking as if abortion was *caused* by the Abortion Act, came to an end. It is rubbish. Abortions occur. All doctors can do, and certainly have an obligation as doctors to do, is to try to ensure medical care for the woman where they can. And it is for this that the Act provides. Has a woman no right to compassion and medical care in unwanted pregnancy?

What Mr. White's Bill will do is to deprive the majority of women of medical aid in abortion and the conscientious doctor of *his* "right of conscience" to secure this for his patient, on pain of legal persecution. It will even be a crime for him to discuss her intentions with her. This is outrageous. And, had it not been for the way these aspects of Mr. White's Bill were glossed over to those who voted for it and the Bill slipped through quickly under its acceptable outer cover, it would have been flung out, as it should have been and should be now, as an affront to any humane society.—I am, etc.,

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Psychiatry in Russia

SIR,—We recently had the opportunity to meet and confer with Dr. Marina Voikhanskaya, a Russian psychiatrist just arrived from Leningrad. Her testimony removed any vestige of doubt that Soviet psychiatrists certifying dissidents and human rights workers for compulsory detention know full well that there are no clinical grounds for detaining these "patients," who are wrongfully certified for reasons of political convenience. Psychiatrists in charge of dissidents in "special" and ordinary psychiatric hospitals are also cognisant of these facts and do *not* merely construe the concept of mental illness differently from their colleagues in the West. Hearing Dr. Voikhanskaya's evidence has convinced us that allegations of bad faith and misuse of psychiatry in the Soviet Union are all too well founded. She has asked us to submit