A question of conscience

SIR,—The article by Mr R Walley (12 June, p 1456) is of the very greatest importance to the public and to the medical profession. The account which Mr Walley gave of the pressure put on him to agree to carry out abortion against his conscience is a more fully explained example of this method of appointing consultant gynaecologists than others recorded before. The Department of Health must make sure that women know how and where they can obtain, at the right time, an abortion if they wish to have one, and if the Department requires more abortions than its gynaecologists are able and willing to supply it must supplement them by the appointment of regional or area medical abortionists.

Whether a candidate believes that abortions should be on demand or restricted, he should answer the questions put to Mr Walley by saying, "I shall do what I think is right and best for each patient." Further, it is time that physicians and surgeons made a similar declaration of conscience, for they should not leave their patients and themselves open to the risk that doctors could be threatened, by bureaucratic directive, to maltreat people in the way that has already happened in some other countries. The royal colleges should give a strong lead on this before the vandalism of the relation between the public and the medical profession goes a step further.

In the meantime it would be valuable to know the outlook of the members of the appointment committees who advised Mr Walley to go to work abroad. Was it cynicism or despair? At any rate, it could cause many other doctors and nurses to shun the NHS. Can the Department convince anyone that it will suppress dragooning of the kind that Mr Walley and others have experienced, or should the Minister be taken to court for making a directive which takes away the benefit to Mr Walley and others of the conscientious objection clause of the 1967 Abortion Act?

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SIR,—Mr R Walley's "Personal Paper" (12 June, p 1456) shocked me profoundly. Those of us who recall the policy of appointing to mental institutions in Nazi Germany only those doctors prepared to take part in "euthanasia" of mentally defectives must recoil from the implications of the policy he encountered. At the exit of the commemorative exhibition at Dachau concentration camp a wall bears the legend, "Those who do not remember history may well repeat it."

LILLIAN VERSTEEG

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Management of eclampsia

SIR,—Your leading article on eclampsia (19 June, p 1485) gave an informative summary of the therapeutic management of this condition. It is a pity that the place of caesarean section was dismissed with the perfunctory sentence, "There is no strong evidence in favour of routine caesarean section." Perhaps there is not, but one can say with equal truth that there is no strong evidence in favour of routine conservative management either. My opinion is that, provided an experienced

anaesthetist is available, caesarean section is an absolutely marvellous treatment, not only for eclampsia but also for severe pre-eclampsia, for these reasons: (1) while the patient is anaesthetised there is no possibility of a fit occurring; (2) it is the quickest way to empty the uterus and reverse the basic pathology, whatever that may be, and incidentally to halt the progress of the coagulation defect; (3) it is the most rapid method of rescuing the fetus which, if it has survived the first fit, is in constant peril; (4) furthermore, should the patient have inhaled vomit, nobody is in a better position thoroughly to clear the bronchi of secretions and give the patient oxygen than an anaesthetist. I therefore believe that caesarean section is the treatment of choice except when a vaginal delivery can be expected very soon (within an hour or so)—that is, when labour is well established, the presenting part is low, and the cervix nearly fully dilated.

An important feature of this disease not mentioned in your article is that a proportion of fits occur after delivery—and this is a very dangerous period as vigilance tends to relax.

It is perhaps worth a passing mention that convulsions due to causes other than eclampsia can occur in pregnancy and in labour; they are probably more common in the subtropics than in a temperate climate. Epilepsy, of course, springs to mind, but also parasitic diseases can be a cause, of which malaria is one. I have seen a case of cerebral malaria (malignant tertian) present as convulsions in a woman 39 weeks pregnant.

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"Practical Medicine"

SIR,—We should be grateful for an opportunity to comment on your review of our book *Practical Medicine* (15 May, p 1218). Your reviewer states that the aims of the book have not been achieved. However, from the examples given, he seems to have so far misunderstood the aims of the book as to give his comments little relevance. The book is intended as a problem-orientated approach to general medical outpatient work for junior physicians recently trained in diagnostic methods and clinical pharmacology. To have included, as your reviewer suggests, paediatrics, dermatology, ophthalmology, psychiatry, and therapeutics would have enlarged the book into a comprehensive compendium more suited to the reference library than to the practising clinician's pocket. Similarly, the reviewer cannot be serious in suggesting that the management of acute myocardial infarction has a place in a book on outpatient care.

It is disappointing that the reviewer resorts to the well-known journalistic trick of quoting out of context. We are accused of a dangerous error of fact—namely, "the statement that oxprenolol is cardioselective, with little effect on asthma." The book in fact states, in the section on *drug intolerance in asthma*, that oxprenolol has "relatively little effect on asthma (as compared with propranolol) but that it should still be suspect in any case of asthma that is difficult to control."

We fully accept that details of clinical pharmacology are omitted and that some of the most commonly used drugs have not been indexed. This was intentional but may well

have been misjudged, and we are grateful for the reviewer's opinion.

We never intended to write a fully comprehensive medical textbook; there are already a large number available. We hope that our book will help the junior physician and others to make safe and sensible decisions in the medical outpatient setting. Your review has not tried to assess the book in this light and consequently can be of little use to prospective readers.

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Age of menarche

SIR,—May I correct Dr P H W Rayner (5 June, p 1385)? The age of menarche has *not* decreased progressively since records were first kept. Dr D F Roberts and I have published two papers^{1,2} showing that the downward trend in the age of menarche stopped over 10 years ago. The mean age of menarche is now stable at about 13.2 years. It is perhaps significant that Dr Rayner's only quoted reference is to a book published 14 years ago. The author of this book is in fact one of several people both here and abroad who have supported our observations.

Since Dr Roberts and I published our first paper we have had to point out to apparently authoritative authors in various respected medical journals that the secular trend towards earlier menarche is no longer continuing. I have written to gynaecologists and endocrinologists and now I must add a paediatrician to the list. When, sir, will they ever learn?

T C DANN

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¹ Dann, T C, and Roberts, D F, *British Medical Journal*, 1973, **3**, 265.

² Roberts, D F, and Dann, T C, *British Journal of Preventive and Social Medicine*, 1975, **29**, 31.

Treatment of dermatomyositis

SIR,—We would like to amplify your expert's reply (13 March, p 637) and the comment by Dr W F Durward (29 May, p 1341) on this topic as a consequence of a survey recently undertaken in this unit¹ on the prognosis and response to treatment in 118 cases of polymyositis.

Most of the patients had been treated with high doses of corticosteroids, though a few had also received immunosuppressive therapy. The mortality in patients with polymyositis as a whole was about four times that of the general population. With high doses of corticosteroids 66% of the survivors with polymyositis had no significant functional disability three years after presentation, and the prognosis for recovery was even better in survivors with dermatomyositis. Though we have not carried out a controlled trial, our experience agrees with that of Benson and Aldo² that oral azathioprine leads to a higher rate and extent of recovery than corticosteroids alone. We find oral azathioprine much easier and safer to use than the intravenous schedule of methotrexate recommended by Metzger *et al.*³

Our suggested treatment regimen is to begin with prednisone 50-100 mg daily,

subsequently decreasing the dose according to the clinical response to achieve a maintenance level sufficient to suppress the signs of disease activity (usually 5-15 mg daily). If the response in the first 3-4 weeks is satisfactory we often then begin alternate-day rather than daily treatment. If there is no marked improvement in clinical signs or in the level of serum creatine kinase activity after two months of treatment with high doses of prednisone, then we add azathioprine 2.5-3 mg/kg per day in divided doses, adjusting the dose to lower the total lymphocyte count to about $1.0 \times 10^9/l$ (1000/mm³). In a few cases it is necessary to maintain high doses of both drugs for up to six months before significant improvement is obtained, though most patients respond much more rapidly. After two years we attempt to tail off the treatment very gradually indeed, following the clinical state and the serum creatine kinase activity. If after any reduction there is evidence of recrudescence of disease activity higher dose levels are reinstated; slow withdrawal is again attempted every year until the disease has burned itself out.

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- ¹ De Vere, R, and Bradley, W G, *Brain*, 1975, **98**, 637.
² Benson, M D, and Aldo, M A, *Archives of Internal Medicine*, 1973, **132**, 547.
³ Metzger, A L, et al, *Annals of Internal Medicine*, 1974, **81**, 182.

Routine preoperative chest radiography

SIR,—Mr A M Rees and his colleagues (29 May, p 1333) make a strong case for re-examining the usefulness of preoperative chest radiography. It is worth bearing in mind, however, that, of all the *post-operative* chest complications, embolism is probably the commonest and can be very difficult to diagnose. The clinical signs may be equivocal and the lung scan ambiguous. A recent preoperative radiograph of the chest is then of great help in assessing minimal and often subtle postoperative changes, enabling a firm diagnosis to be made and anticoagulant treatment started. This applies to young as well as to older patients.

GORDON EVISON

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Treatment of metabolic alkalosis

SIR,—Dr S E Williams (15 May, p 1189) describes a treatment for metabolic alkalosis that involves cannulation of a central vein and infusion of dilute hydrochloric acid. There is a simpler and no less physiological method that is illustrated by the following case.

A 55-year-old man was admitted in oliguric hypovolaemic renal failure (plasma creatinine 640 mol/l (7.25 mg/100 ml)) and with a metabolic alkalosis (Cl 60 mmol/l; HC03 54 mmol/l). He was confused and agitated, with frequent involuntary jerking of his limbs. Vigorous fluid replacement was undertaken, plasma and normal saline with potassium supplements being used. Despite restoration of blood volume and correction of other electrolyte levels the serum chloride remained low (65 mmol/l at 24 h). The neuromuscular irritability persisted and he continued to be disorientated. A rectal infusion of 2 l of 5% calcium chloride was given over six hours. During this time he became

rational, the twitching subsided, and the serum chloride rose to 90 mmol/l. Subsequent investigation showed a carcinomatous obstruction and a bypass operation was done.

Continuous rectal infusion (proctoclysis) was introduced by J B Murphy in 1908, but its use has declined with the development of intravenous techniques. It is particularly suitable for treating hypochlorhaemia because differential absorption of chloride ion occurs across the colonic wall, with little retention of fixed base.¹ The infusion is easily set up and supervised by nursing staff, is not hazardous, a sepsis is superfluous, and isotonic fluids are not required. What more could one ask for?

I am grateful to Dr A M Davison, St James's Hospital, Leeds, for permission to report this case.

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- ¹ Parsons, F M, Powell, F J N, and Pyrah, L N, *Lancet*, 1952, **2**, 599.

Prostaglandins in depression

SIR,—The report by Drs Georgia Nikitopoulou and J L Crammer (29 May, p 1311) that changes in body temperature occur during the depressive phase of manic depression, if confirmed, is of great interest. There is a distinct possibility that changes in cerebral prostaglandin (PG) levels may explain changes in temperature regulation and in neuronal noradrenaline and serotonin levels in depression.

PGs of the E series increase temperature by an effect on the hypothalamus.^{1,2} Thus a change in temperature regulation may indicate a change in hypothalamic PGE₂ content or altered hypothalamic response to PGE₂. PGE₂,³ and possibly PGF₂α are involved in the control of noradrenaline efflux from sympathetic nerves, and PGE₂ has recently been shown to inhibit noradrenaline and serotonin release from central neurones in the rat.⁴ Some time ago I suggested that prostaglandins might play a part in premenstrual depression.⁵ There is some evidence that prolactin may be involved in premenstrual depression⁶ and that some effects of prolactin may be mediated by PGF₂α.⁸ May I urge those with research facilities to investigate the role of prostaglandins in depression?

G M CRAIG

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- ¹ Vane, J R, *Nature New Biology*, 1971, **231**, 232.
² Stitt, J T, *Journal of Physiology*, 1973, **232**, 163.
³ Hedqvist, P, *Acta Physiologica Scandinavica*, 1970, suppl 345.
⁴ Brody, M J, and Kadowitz, P J, *Federation Proceedings*, 1974, **33**, 48.
⁵ Masek, K, and Kadlec, O, in *Advances in Prostaglandin and Thromboxane Research*, ed B Samuelsson and R Paoletti. New York, Raven Press, 1976.
⁶ Craig, G M, *Postgraduate Medical Journal*, 1975, **51**, 74.
⁷ Horrobin, D F, et al, *Postgraduate Medical Journal*, 1976, **52**, suppl 2, p 80.
⁸ Rillema, J A, *Nature*, 1975, **253**, 466.

Erectile impotence

SIR,—Your leading article on this subject (29 May, p 1298) overlooks a very important aspect of the problem. While it must be accepted that the entrenched and consolidated case of erectile dysfunction is often resistant to treatment, every case of impotence passes through a mild and usually readily reversible

stage. Unfortunately this stage is rarely presented to the general practitioner unless he consciously searches for it. The majority of doctors are disinclined to uncover a condition which they feel incompetent to treat. The nub of the problem is therefore inadequate medical education in the field of sexual dysfunction.

My involvement in this field is at several levels. Firstly, as a general practitioner I am aware of the need to be sensitised to the hint, however gentle or disguised, of sexual anxiety. I know from long experience that the chance of successful treatment at this time is very high. One needs to take a little time and trouble in sorting out the ramifications of the disability and not to rush in with a prescription for behavioural tasks. It is as easy to prescribe so-called Masters and Johnson's therapy as it is to write a prescription for drugs. Both can be very effective at the right time. Both can be harmful if carried out before listening, before understanding, before interpreting.

My second hat is worn at my weekly psychosexual problems clinic at the Newcastle General Hospital. Here I am being consulted by patients referred by general practitioners, gynaecologists, family planning doctors, physicians, etc. My success rate is lower in this setting and yet I know this is not because the patients are suffering from a more intractable form of dysfunction. It is only too obvious that many of them are images of the patients relatively easily treated in general practice but now at a more advanced stage of the condition.

And so my third hat is an educational one, both at an undergraduate level (where the new curriculum at Newcastle will contain significantly more teaching in the area of sexual dysfunction and at postgraduate level) where a group of about 40 doctors is involved in a two-year course on managing psychosexual problems. In both cases the emphasis is on early detection and comprehensive diagnosis.

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Cervical smears

SIR,—The article by Mr G Brindle and others (15 May, p 1196) on the selection of women for uterine cervical smears is timely.

In this region, out of 41 863 women examined for the first time under 25 years of age, only 3 per 1000 were found to have carcinoma-in-situ and there were only two cases of microinvasion. Occasional clinical cases have occurred in this age group, but the incidence is very low compared with that of the older age groups. The majority of the cases detected were in women attending ante- or post-natal clinics. The detection rate at ante-natal clinics was three times higher than at postnatal clinics. The high-risk women default from postnatal clinics.

The number of smears obtained from this under-25 age group increased threefold between 1966 and 1974, largely because of smears from family planning clinics. With the co-operation of the FP doctors smears are now taken only before a woman starts to take the contraceptive pill or has an intrauterine device fitted. Repeat smears are taken according to the normal routine.

To concentrate screening on the 40-year age group, where the yield is highest, would be ideal, but it is difficult to reach all of this group for the first time. The fact that this age group