Effects of legal termination on subsequent pregnancy

SIR,—We are sorry that our Bristol colleagues Drs Ruth E Coles and Beryl A Tully (3 July, p 45) seem to feel that our belief (29 May, p 1303) that it seems reasonable to assume that patients who ask that their general practitioners are not informed of their termination will not admit to termination during a future pregnancy casts some sort of slur on such excellent organisations as the Brook Advisory Centre in which they work.

If our statement was capable of such misconstruction then we do indeed apologise, but the fact remains that we have in our own experience recently encountered two women who attributed their lower abdominal scars to urological surgery in one case and an ovarian cystectomy in another and who, during the course of the pregnancy that we had charge of, ruptured the hysterotomy scar which they had denied. It is, of course, not possible to know how many women who have had vaginal terminations withhold this information from their obstetrician, but we do not think it unreasonable to assume that such concealment does occur if the far more dangerous procedure of abdominal hysterotomy is denied.

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Compensation for drug side effects

SIR,—I read with dismay that Imperial Chemical Industries are paying out sums expected to amount to over £1m in "compensation" to patients who suffered side effects of the drug practolol (Eraldin). Were ICI negligent in the conduct of their clinical trials? Were they dishonest in the presentation of their results to the Committee on Safety of Drugs? Have they withheld information about adverse reactions from the medical profession? I have heard no suggestion that they are guilty of any of these offences; in that case their only fault is ever even to have considered claims for compensation. If they are guiltless they are not liable and they should say so.

It would be just as reasonable for the victims of side effects to claim compensation from Sir Derrick Dunlop as chairman of the Committee on Safety of Drugs that approved practolol or from the doctors who prescribed it. No doubt the possibility of suing the latter will have occurred to them, and if they did not follow that course of action it was probably because their legal advisers told them that the medical defence societies' lawyers would demolish them. Is it conceivable that ICI have access to less competent lawyers than the medical defence societies or are they feebly following the line of least resistance, disguising their gutlessness as humanitarianism?

The fact is that the unfortunate few who suffered as a result of treatment with this drug cannot reasonably hold anyone to blame any more than if they had been struck by lightning. If ICI meekly pay compensation just because they are rich manufacturers and the injured parties are poor patients it will very soon become accepted that to spend millions of pounds discovering, developing,

manufacturing, and marketing a drug that saves lives and relieves suffering is an offence that deserves to be punished.

That is not to deny that patients who suffer injury through no fault of their own should be compensated, but in the present state of the law in Britain, there is no fund from which people suffering injury, disablement, or even death can properly demand compensation unless they can prove that someone is to blame. It is incomprehensible that any government, especially one that prides itself on being "compassionate" and which cannot do too much to compensate people for loss of employment even when they lose it through their own fault, is apparently unwilling to do anything for those who suffer injury due to no fault of their own or of anyone else's. Or is it? So long as commercial firms such as Distillers and ICI are prepared to provide huge sums of money for this purpose perhaps it would be unfair to blame the Government for not hastening to pre-empt them.

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Reducing outpatient attendances

SIR,—I would like to support the views expressed by Mr R M Kirk (19 June, p 1521). There is no doubt that patients are asked to attend outpatient clinics far too often and that many issues can be sorted out by post or telephone after the initial visit.

I have been attempting to cut down patients' visits to my outpatients' clinic at this hospital by using the methods outlined in Mr Kirk's paper. I can confirm how well it works to the mutual benefit of the patient and the doctor. I believe that the reason that we can do this easily at St John's is because we are a small specialist hospital. The results of all investigations come back to the doctor who saw the patient and he goes through these at the start of each clinic. Reports very rarely go astray and they are never filed until they have been seen by the doctor. It is then very easy to ask for the case-notes to be retrieved and a letter can be dictated to the patient and the family doctor with the results.

It is very often the case that patients need to be seen again for medical purposes, but it often happens that they are brought back purely to hear the results of tests. If action needs to be taken because of the test results a letter to the patient and his family doctor will often suffice or else a further appointment can be sent. If a patient has a skin eruption that I expect to be cured within a limited period of time I will often give him an appointment to come back but ask him to phone me a few days before if he is completely clear; this saves him a visit and allows another patient to be fitted in.

There are many ways in which these ideas can be developed. I think the system can work smoothly in a small establishment like ours, where all the staff know each other. In a large general hospital it would probably be much harder. Results of tests cannot be relied upon to reach the doctor's tray, and the patient's case-notes are more likely to be mislaid. In spite of these difficulties it ought to be attempted. I think we are not sufficiently sensitive to the very great difficulties that patients have in attending as outpatients, especially in a large city like London. Anything we can do to

reduce their visits is important. There is also benefit for the doctor in that he can concentrate on giving a better service to a smaller number of patients in a slightly more relaxed environment.

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Adverse reactions to practolol

SIR,—A recent paper by Dr J C Petrie and others, entitled "Methyldopa and propranolol or practolol in moderate hypertension" (17 July, p 137) may have given some doctors and pharmacists the impression that practolol is still considered to be a suitable drug for the treatment of hypertension. The paper did not refer to the ocular and other dangerous complications of practolol therapy which have led to its withdrawal from general use.

The Committee on Safety of Medicines advised the profession about the hazards of long-term therapy with practolol in January 1975 (Adverse Reactions Series No 11), but later in the year when further reports were received it was decided that supplies should be restricted to hospitals for use for patients with certain cardiac dysrhythmias only.

The committee wish to remind doctors and pharmacists that in view of the dangers of practolol its use should be limited to the control of certain acute cardiac dysrhythmias in hospitalised patients with organic cardiac disease. Clearly in view of the unacceptable incidence of serious adverse reactions practolol is generally unsuitable for the treatment of angina or hypertension.

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Carpal tunnel syndrome and tennis elbow

SIR,—The symptoms of "spontaneous" median nerve compression in the carpal tunnel are frequently aggravated by occupations involving repetitive hand movements, such as knitting and packing. Some authors have concluded that occupation is indeed a causal factor,^{1,2,3} and Gunn,⁴ in a letter to the *BMJ*, reported that the carpal tunnel syndrome is frequently encountered by the Worker's Compensation Board of British Columbia. Tennis elbow (lateral humeral epicondylitis) may also be considered to be an over-use phenomenon, being aggravated by activity and relieved by rest (and local corticosteroid injections).

Dr C F Murray-Leslie and Professor V Wright (12 June, p 1439) showed that 33% of 43 patients with proved carpal tunnel syndrome had also suffered from tennis elbow, whereas only 7% of controls matched for sex and age had this problem. We have analysed 138 cases of carpal tunnel syndrome confirmed by nerve conduction studies. Ninety of the patients underwent surgery and 48 recovered after hydrocortisone injection alone. The prevalence of symptomatic tennis elbow was 8.9% and 16.7% respectively. The lower overall prevalence in our patients could be because signs of tennis elbow were sought only after a spontaneous complaint by the patient.

Could the greater prevalence of tennis elbow found by Dr Murray-Leslie and

Professor Wright in their patients with carpal tunnel syndrome than in the controls be due to the fact that they were not matched for occupation and that the former group were more active manually?

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¹ Brian, W R, Wright, A D, and Wilkinson, M, *Lancet*, 1947, 1, 277.

² Kendall, D, *British Medical Journal*, 1960, 2, 1633.

³ Birkbeck, M Q, and Beer, T C, *Rheumatology and Rehabilitation*, 1975, 14, 218.

⁴ Gunn, C C, *British Medical Journal*, 1974, 3, 624.

Bromocriptine and breast cancer

SIR,—In the light of recent articles concerning bromocriptine your leading article "Hormone receptors and breast cancer" (10 July, p 67) raises the possibility of the use of this drug to suppress the growth of prolactin-dependent breast tumours since, as you say, "the main peptide hormone implicated in promoting the growth of breast tumours is thought to be prolactin."

The theoretical and to some extent substantiated fear of oestrogens and other hormones as carcinogenic agents should, however, perhaps now be extended to include other drugs which interfere with man's delicately balanced endocrine functions—for example, phenothiazines, methyl dopa, and even indeed bromocriptine, which is used to suppress puerperal lactation, a physiological state which in itself affords some protection against breast cancer.

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Eggs and hypercholesterolaemia

SIR,—I was interested to read Professor V Lindén's comments (10 July, p 109) on the case report by Dr H P Rhomberg and Professor H Braunsteiner (15 May, p 1188). He suggests that the excessive hypercholesterolaemia following a daily intake of 8-12 eggs daily extending over a period of 3½ years can be mainly ascribed to the high vitamin D content in the yolk of eggs. Evidence is quoted which indicates that an excess of vitamin D raises the serum cholesterol level, thus leading to a significant relationship between a high intake of vitamin D and the incidence of myocardial infarction.

However, an excess of vitamin D also leads to increased calcium absorption and to an increased serum calcium level. In extensive animal experiments Selye *et al*¹ have shown that an acute heavy overdose of vitamin D compound leads to general metastatic calcification. The chronic administration of less massive doses of vitamin D causes calcification which is almost entirely confined to the aorta and its main branches and to the coronary arteries. Many pathologists and my own investigations² suggest that calcium deposits in the media of the large human arteries are one of the essential preliminary processes in atherogenesis. A high serum cholesterol, whether of endogenous or exogenous origin, seems to have an accelerating effect on atheroma formation when the ground has been prepared by ageing processes in the arterial wall.

In the case referred to a return to a balanced diet led to the disappearance of the skin deposits consisting mainly of lipids. The same response is less likely to occur in the case of atheromata.

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¹ Selye, H, Strebel, R, and Mikulaj, L, *Journal of the American Geriatric Society*, 1963, 11, 1.

² Elkeles, A, *Journal of the American Geriatric Society*, 1976, 24, 58.

High-dose corticosteroids in severe acute asthma

SIR,—The comparison of different corticosteroid regimens in acute asthma by Dr M G Britton and others (10 July, p 73) deserves further comment. The use of three different corticosteroids given by four different routes hinders easy comparison between the three groups. The fact that only one group received an intravenous infusion introduces a further difficulty.

The variability of the results in the small groups examined makes it difficult to come to any confident conclusions about the findings. The authors correctly use standard errors for comparing peak flow, REV₁, and FVC. However, the values quoted are very high and back-calculation of the standard deviations gives negative values well within the lower end of two standard deviations. It is patently absurd for any individual to have a negative value for a lung function test, and clearly a correction for skewness is required. Even if this is made, variations about the mean will probably still be large and the only likely conclusion should still be that the small patient numbers used in multiple patient groups give results which are very variable so that, taken overall, no statistically significant difference can be detected and likewise no useful clinical difference is detectable. The wide variation within each group is also likely to obscure any minority of patients failing to respond to smaller steroid doses. It may well also be true that high-dose steroids confer no extra benefit, but clear proof is still lacking.

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Rubella antibody tests in pregnancy

SIR,—The letter from Drs D A McSwiggan and C E D Taylor (17 July, p 174) is timely and highlights some of the difficulties encountered in using the results from testing pregnant women for rubella antibodies to best advantage.

For several years this laboratory has made these tests on all blood samples submitted from antenatal clinics and more recently those women with no evidence of immunity to rubella have been offered vaccination against rubella in the immediate postnatal period. Since general practitioner records do not appear to hold this information readily available it was hoped that the women themselves would be made aware of their immune status. In this way the intense anxiety which many experience when they are pregnant and come into contact with a case of presumed rubella would be avoided and the number of sera submitted for this reason would be

reduced. Experience has shown that this optimism was not justified, for the number of women seen because of this is as high as ever. If the first baby was born in our catchment area our own records or a single telephone call reveals the result of any previous test and usually offers immediate comfort to the anxious patient, though the serum is still tested in parallel with any previous sample which might still be frozen in store.

In this area we have therefore adopted the practice of giving all women who have had their babies in the maternity units a notice which gives dates and identification details and goes on:

Rubella titre:.....
You are immune to rubella (German measles)

If there is no evidence of immunity to rubella and vaccine has been given the second line of the notice is deleted and the administration of vaccine is recorded on the slip. It is hoped that this, and the explanation given, will enable the women themselves to know and perhaps remember this information.

In recent weeks an encouraging number of sera have been submitted from family planning clinics. It is to be hoped that the number will increase and the patients will be informed of and understand the significance of the test. There remain groups who, surprisingly, are unaware of their immune status and who should know before they become pregnant. These are schoolteachers, play-group helpers and supervisors, district nurses and midwives, nursery nurses, social workers, and house-mothers at council homes. Efforts to get these groups to be tested have been unrewarding so far, but wider publicity from general practitioners—for example, by notices in surgery or health centre waiting rooms—might be effective.

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Nitrazepam and diazepam

SIR,—Dr F O Wells (3 July, p 48) advocates the use of diazepam in place of nitrazepam as a safe, effective, and infinitely cheaper product. While this may well be accepted in the young and middle-aged adult, I venture to suggest that in the elderly patient with a failing autonomic nervous system the occurrence of postural hypotension with diazepam is a very real and serious risk. Falls from bed (these usually mean falls on getting up to go to commode or lavatory) are all too frequent in the elderly, often resulting in severe bruising and shock and sometimes in fractures of the femur and elsewhere.

Over the past two years it has been routine in this unit to measure the blood pressure in the erect as well as the supine position in all patients who have had falls or who complain of vertigo when standing. The prevalence of severe postural hypotension found has been quite staggering, and diagnoses of vertebro-basilar ischaemia, drop attacks, and transient ischaemic attacks have been correspondingly reduced, the first to an almost negligible level. The vast majority of these cases were clearly due to drugs, as the blood pressure stabilised completely or substantially within a few days of stopping them. Of the drugs responsible, excluding levodopa in Parkinson's disease, one-third were legitimate hypotensives perhaps