count, the clinical picture and the markedly increased liver enzyme values were misleading and the protein-bound iodine result was thought to be erroneous. Thus the patient was on parenteral nutrition for almost two weeks before a firm diagnosis was made. The treatment resulted in dramatic improvement within a few days.

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SIR,—The paper by Dr F D Rosenthal and others (24 July, p 209) prompts us to record a recent patient with thyrotoxicosis who, while not vomiting, was decidedly liverish.

A 63-year-old farmer presented with three months' history of loss of weight (25 kg), shivering, sweating, and high backache. Mild scleral icterus and a pulse rate of 90/min were present together with a palpable liver edge and a palpable spleen. Initially the patient was investigated for neoplasm with a negative result. A serum thyroxine concentration of 412 mmol/l (32 mg/100 ml) reverted to within normal limits (46–148 mmol/l (5–11.5 mg/100 ml)) after treatment with radioactive iodine, as did abnormal liver function tests, the serum bilirubin level falling from 44.5 μ mol/l (2.6 mg/100 ml) to 13.7 μ mol/l (0.8 mg/100 ml), serum albumin rising from 28 to 37.5 g/l and total protein from 55 to 70 g/l, and the Thrombotest result rising from 45% to 100%.

Dr Rosenthal and his colleagues mention "slightly raised" liver enzyme levels in four cases out of seven and in their first case the serum bilirubin level "was raised" at 25 μ mol/l (1.5 mg/100 ml). It is worth remarking that our patient never suffered from anorexia of any kind during the course of his illness and all abnormalities disappeared after treatment with ^{131} I. A subsequent liver scan was normal.

Liver abnormalities have, of course, been described in thyrotoxicosis but rarely of sufficient note to orientate the diagnostician clinically towards a gastrointestinal investigation.

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Management of diabetic pregnancy

SIR,—Your leading article (31 July, p 267) on the management of diabetic pregnancy is rather out of date. Firstly, you observe that the perinatal mortality is now "close to 10%", when in fact it is now much less than this. At this hospital it has decreased from 9% of 176 deliveries in the five years 1966–70¹ to 4% of 144 deliveries in the period 1971–4,² which is maintained at 3.5% when 1975 is included (total of 173 deliveries). This improvement is at least partially due to close collaboration between physician, obstetrician, and paediatrician, which is crucial in the management of diabetic pregnancy in order to achieve the careful antenatal and intrapartum monitoring which is needed.³ Furthermore, quoting a publication now nine years old, you observe that respiratory distress is the most common cause of death, whereas it is now exceptionally rare and we have had no such deaths for several years.² You make no mention of the increasing fetal loss from congenital malformations, which are now the

commonest single cause of perinatal death.^{2,4} Finally, you say that the insulin requirement falls "soon after delivery." In fact the fall is immediate and there is a great danger of very severe hypoglycaemia if the insulin dose, which may have increased two- or three-fold during pregnancy, is not reduced to pre-pregnancy levels on the day of delivery.

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¹ Essex, N, *et al*, *British Medical Journal*, 1973, 4, 89.
² Essex, N, *British Journal of Hospital Medicine*, 1976, 15, 333.

³ Brudenell, M, in *Carbohydrate Metabolism in Pregnancy and the Newborn*, H W Sutherland and J M Stowers. Edinburgh, Churchill Livingstone, 1975.

⁴ Soler, N G, *et al*, *Quarterly Journal of Medicine*, 1976, 45, 303.

* * * The recent figures for perinatal mortality obtained at King's College Hospital are unusually good, but the figure of "nearly or slightly below 10%" may be regarded as more typical in the country generally. The leading article did not say that hyaline membrane disease or "respiratory distress" is the commonest cause of death but rather that it has been found to be the commonest cause of death of babies born prematurely to diabetic mothers, the "has" being used because a relatively old source of information was quoted. The decreased incidence of this cause of death is doubtless due to several factors, of which a significant one is the study of amniotic fluid mentioned in the previous sentence. Considerations of space prevented direct reference to the importance of congenital malformations, but this is one of the main factors which make it, as we said, "increasingly difficult to reduce the perinatal mortality in diabetics any further." The final point, whether the insulin requirement falls "soon after delivery" or "immediately," is hard to judge as the mother usually has an intravenous drip of glucose running at this time, but certainly the insulin dose should be decreased from the time of delivery.—Ed, *BMJ*.

Urinary retention in women

SIR,—I am glad that the letters from Mr S L R Stanton and Mr T Moore were published together (14 August, p 420). I see about one woman each year who has "female prostatic obstruction" exactly as described by Mr Moore; as he says, they respond well to the removal of the obstruction by endoscopic resection. So I am surprised that Mr Stanton found no such case in his series of 27 women with retention or a slow stream.

But why does Mr Stanton consider pressure-flow studies with sphincter electromyography so important? It is safe to assume that his 27 patients were thought to have "acute retention," "chronic retention," or "a noticeably slow stream" as the result of a good history and a simple examination. To determine a drug-induced aetiology requires only careful inquiry and the trial substitution of the drug thought responsible. Similarly, a neurological aetiology is surely determined by the history and the relevant clinical examination. Maybe there is now a urodynamic finding that is actually diagnostic of hysteria, but I doubt it.

I have seen two women with retention which had been elsewhere considered to be due to hysteria. One, with repeated painful episodes of acute retention, had a cyst of the urethra and trigone; the other, with chronic retention, had a "female prostate"—both responded well to endoscopic resection.

In 1976, when impecunious area health authorities like mine cannot provide a consultant with a desk, let alone an office, it behoves the teaching hospitals to consider carefully, when advocating such very expensive gadgetry, whether equally good results could not be obtained with a pin and a bit of cotton-wool.

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SIR,—While I am in agreement with Mr S L R Stanton (14 August, p 420) that hysteria may be an important aetiological factor in many cases of acute retention of urine in women, I must disagree that chronic retention "may be considered to be the result of a single or repeated episode of acute urinary retention."

Once obvious obstructive urological (for example, stone, tumour), neurological, and gynaecological lesions and a history of drug ingestion have been excluded we believe that chronic urinary retention is not a single entity but consists of at least two different aetiological groups. The first is characterised by a residual urine volume of less than 500 ml and displays the self-perpetuating spiral of chronic inflammatory changes at the bladder neck,^{1,2} residual urine, and infection; the second is characterised by the "modesty type" of bladder with a residual urine volume in the region of 1 l or more. While a hysterical personality trait may be found in some of the women in this second group there is, I would propose, no evidence that the first group may progress to the second and no evidence that, except perhaps in an immediate postoperative period, episodes of acute retention of urine in women may pass unnoticed and progress to chronic retention.

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¹ Fox, M, Jarvis, G J, and Henry, L, *British Journal of Urology*, 1976, 47, 797.

² Evans, A T, *Journal of Urology*, 1971, 105, 245.

Abortion and maternal deaths

SIR,—Dr Ann Cartwright in her letter (24 July, p 232) is quite right. There exists much evidence of undue delay in reaching decisions to abort. Certainly, there is enough to justify reforming action now rather than at some unspecified time in the future.

For example, a recent survey¹ in the Cardiff area shows that a significant proportion of family practitioners consider the service at the main hospital (University Hospital of Wales) to be unsympathetic or unsatisfactory or inadequate in substantial part because of delays by consultants in making appointments. Incidentally, the survey shows that about half the women in Cardiff seeking help with termination have to be referred outside the area because of prevailing attitudes at the University Hospital. Only 10 of the 197 family practitioners in the South Glamorgan Area (15% of respondents) were prepared to