report that the service (help with terminations) at UHW was sympathetic or satisfactory or adequate.

Another survey[2] shows that at the University Hospital of Wales only one in five patients referred to the professorial department of gynaecology for consideration of termination was seen within one week of referral; 30% had not been seen within two weeks; 57% of vaginal terminations were performed at or beyond the twelfth week. "Early interview and assessment would enable most terminations to be performed not later than the twelfth week of pregnancy."

The reforming action needed now is simple: a DHSS circular to area health authorities requiring them to make appropriate agency arrangements with one or more of the established non-profit-making voluntary agencies. Family practitioners would then be able to refer locally and the conscientious objections of NHS consultants and others need then not be challenged.

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[1] Family Planning Association, *Where family practitioners in South Glamorgan refer Requests for Help with Termination*, April May 1976 (6 Windsor Place, Cardiff).
[2] Chalmers, I, and Anderson, A, *Lancet*, 1972, **1**, 1324.

Meditation or methyldopa?

SIR,—Your leading article (12 June, p 1421) discusses sympathetic nervous activity in hypertension, suggests that mild cases may benefit from transcendental meditation (TM) or yoga, and points out that the scope for such treatments is undefined. These are but fragments of two major problems facing us today. The first is the extent to which hypertension and its related cardiovascular disorders are the outcome of a morbid relationship between the individual and his environment—that is, of a relationship that creates excessively severe and prolonged arousal leading to fatigue and exhaustion.[1 2] The second is the extent to which relief from these disorders should be obtained by modifying the morbid relationships, as opposed to "treating" the raised blood pressure pharmacologically as if it was a "disease" in its own right.

Of 67 patients admitted for routine investigation and treatment of hypertension (range 160/100-230/130 mm Hg) 33 (50%) became normotensive when the arousal and exhaustion were treated. In 26 (39%) the blood pressure fell to normal levels on some occasions but failed to stay there consistently. In one patient admission to hospital was not well tolerated and his blood pressure rose. Only in seven (9%) did the blood pressure fail to respond to the treatment of the arousal. Of these seven, two had renal failure, one had renal carcinoma, and four had to be regarded as fixed-essential hypertension. Of the 33 patients who recovered normal blood pressure one-third had arrived at the point of exhaustion and ill health[2] because their behaviour was maladaptive, and two-thirds had been brought down by circumstances causing extreme frustration and anger or despair and hopelessness.[3-8]

The hospital methods for reducing arousal included the sleep regimen as employed in myocardial infarction,[9] lighter levels of sedation, a warm and caring atmosphere, and the creation of a support group for the period of the patient's need. An attempt was made to teach every patient to recognise the level of arousal and fatigue that made his blood pressure high and to be responsible for his own care. In the longer term the patients were taught to use diazepam as a defence against morbid arousal and encouraged to learn how to reduce arousal at will, a method advocated by Mackenzie.[10] Some were taught to relax and others adopted TM or yoga. All were taught to regard sleep deprivation as dangerous.

Economically we believe that a great saving could be made if the initial routine investigation became the general practitioner's observation of the blood pressure response to the reduction of arousal and the removal of exhaustion at home. It is reasonable to agree with Pickering's[11] contention that established hypertension can be the outcome of long periods of transiently raised blood pressure and that the transient rises have much to do with the patient's "behaviour of mind" or arousal. A greater medical awareness of the heightened sympathoadrenal activity of life on fatigue and exhaustion, a wider recognition of maladaptive behaviour, and a much closer inquiry into the patient's attitudes and circumstances might lead to "essential" hypertension becoming inessential.

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[1] Nixon, P G F, in press.
[2] Kagan, A R, and Levi, L, *Social Science and Medicine*, 1974, **8**, 225.
[3] Lorenz, K, *On Aggression*. London, Methuen, 1970.
[4] Kennedy, A, *Lancet*, 1957, **2**, 261.
[5] Chambers, U N, and Reiser, M F, *Psychosomatic Medicine*, 1953, **15**, 38.
[6] Birley, J L T, *Proceedings of the Royal Society of Medicine*, 1973, **66**, 96.
[7] *British Medical Journal*, 1971, **2**, 215.
[8] *British Medical Journal*, 1975, **1**, 458.
[9] Nixon, P G F, *Practitioner*, 1973, **211**, 5.
[10] Mackenzie, L, *Diseases of the Heart and Aorta*. London, Oxford Medical Publications, 1908.
[11] Pickering, G, *Lancet*, 1976, **2**, 1403.

Consent and intrauterine contraception

SIR,—In the medicolegal columns (31 July, p 310) you quote the advice of the Family Planning Association on the obtaining of husband's consent for the insertion of an intrauterine contraceptive device. In my opinion the advice is unhelpful and confusing if not actually contradictory. It seems that the alternative to the husband's agreement is for the doctor to be satisfied that the insertion is "reasonably necessary for the proper treatment of the wife." This being so, unless the financial inducement is greater than one had imagined, what is the need to weigh up the wife's assurance about her husband's agreement? Surely there is no other reason for inserting such a device than that it is "reasonably necessary."

In what way does the keeping of routine notes exonerate the doctor from obtaining the husband's consent, if indeed consent is necessary? Is not the purpose of the notes to record when the wife withholds permission to communicate with her husband, or that the husband withholds his consent? Does such a record really upset the husband's legal rights? This surely is the crux of the matter. Has the husband the right to give his wife a child regardless of her own wishes? The insertion of an intrauterine device at best, or worst, depending upon one's viewpoint, does not permanently deprive him of this right, if indeed he has it. If he has such a right he has the normal processes of the law to recover it if he considers he has been improperly deprived of it. However, the doctor who deprived him of his right albeit temporarily may need protection.

It is not sufficient for the FPA to issue advice or make recommendations as to practice in its clinics. The doctors practising in such clinics need a clear statement of the law and if the law is ill defined or unsatisfactory have the right to expect that our legislators will amend it to bring it into line with other recent social legislation affecting the status of women. Meanwhile, if a man has the legal right to have children by his wife and to decide when to have them, regardless of her wishes, it is dangerous for a doctor to interfere with that right. Now that most FPA clinics have been or are being transferred to area health authorities the DHSS surely has an obligation to clarify the legal position and if need be to initiate action to change it.

In the meantime many doctors working in family planning clinics are not seeking the agreement of the husband or the wife's assurance of it. They believe such agreement to be unnecessary and derogatory to the status of women. Neither for that matter do they seek the permission of the wife before supplying her husband with condoms. The BMA would be doing these doctors a service if it sought to clarify this matter now rather than leave it to the courts to decide.

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Uraemic bullae

SIR,—During the summer of 1975 two middle-aged male patients with chronic renal failure who had not yet started haemodialysis treatment developed bullae on the dorsum of the hands, particularly on the thumbs, and on other exposed areas. One patient had obstructive uropathy and the other had chronic glomerulonephritis. Neither of them had any past history of skin trouble or porphyria. The first patient, aged 47, was taking Slow-K sodium bicarbonate, vitamins B and C, aluminium hydroxide, and large doses of frusemide. The second patient, aged 54, was taking vitamin D, aluminium hydroxide, iron, folic acid, and frusemide 2 g daily. Their blood urea levels were 51·5 mmol/l (310 mg/100 ml) and 30·3 mmol/l (182 mg/100 ml) and plasma creatinine levels 1·9 mmol/l (21 mg/100 ml) and 1·24 mmol/l (14 mg/100 ml), respectively. Similar lesions have been described by Gilchrist *et al*[1] and Korting[2] in patients on haemodialysis; they postulated that the lesions in their patients were a complication of dialysis. Recently Professor A C Kennedy and Dr A Lyell (19 June, p 1509) have described remarkably similar lesions in patients on high doses of frusemide. All but one of their patients had severely reduced renal function.

The clinical similarity of the lesions in these four groups of patients, all of whom were uraemic, is striking. The aetiology is now known. Frusemide could be responsible in our patients, as in the Glasgow patients. However, many patients undergoing conservative treatment for chronic renal failure take this drug. In view of the occurrence of similar lesions in patients on haemodialysis who were not taking frusemide we postulate that these