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

Another survey² 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 health² 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's¹¹ 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 Korting² 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

lesions arise as a result of sunlight on uraemic skin and are not necessarily a drug reaction.

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¹ Gilchrist, B, Rowe, J W, and Mihm, M C jun, *Annals of Internal Medicine*, 1975, 83, 480.
² Kortring, G W, *Dermatologica*, 1975, 150, 58.

Myocardial bleeding in haemophilia

SIR,—We have recently studied 20 severe haemophilic boys at a residential school for evidence of myocardial bleeding. They were aged between 13 and 17, and all had factor VIII levels of less than 1%. So far as we could ascertain there was no clinical evidence of significant myocardial bleeding at any time in their life. We also studied their electrocardiograms for mean frontal axis, T wave changes, and conduction defects. We considered them all to be within normal limits.

It is recognised that muscle bleeding is the second most likely site of haemorrhage after joints in haemophilia.¹ We find it difficult to understand why this does not appear to occur in such an actively contracting muscle bulk as the heart. We could find no report of myocardial haemorrhage in the literature, although pericardial bleeding has been noticed as a post-mortem finding in dogs known to be haemophiliacs.² We would be interested to hear if experience in other centres is similar. If it is, why does myocardial haemorrhage not appear to be a clinical problem?

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¹ Favre-Gilly, J, *Hémostase*, 1964, 4, 231.
² Webster, W P, et al, *Proceedings of Symposium on Haemophilia*, Sidney, Australia, ed I R Vanderfield, 1966.

Hypophosphataemic osteomalacia in patients receiving haemodialysis

SIR,—In some haemodialysis centres osteomalacia is a major component of the progressive osteodystrophy that occurs in a large proportion of patients on regular treatment. There is an increasing awareness of the potential importance of phosphate depletion and hypophosphataemia as part of the aetiological mechanism for the osteomalacia in these patients. The recent paper by Dr J F Mahony and his colleagues (17 July, p 142) was therefore of interest in this respect. In three of their four patients, as in the patient reported by Baker *et al*,¹ the regular oral intake of a phosphate binder in the form of aluminium hydroxide was undoubtedly a major aetiological factor for the phosphate depletion hypophosphataemia and osteomalacia. We were, however, particularly interested in Dr Mahony's fourth patient (case 4), who had progressive osteomalacia and hypophosphataemia but was not taking aluminium hydroxide. We have studied² four haemodialysis patients who had persistent predialysis hypophosphataemia and developed osteomalacia but who had not taken oral phosphate binders for two years or more. The persistence of the hypophosphataemia in our patients was

apparently due to intestinal phosphate malabsorption accentuated by poor dietary intake and continual loss during dialysis.³ Treatment of our patients with oral dihydrotachysterol and increasing the dietary intake of phosphate resulted in marked improvement in four months. Serum 25-hydroxycholecalciferol concentrations in our osteomalacic patients were either normal or increased, an observation which is of considerable interest.

The early detection of phosphate depletion in haemodialysis patients may be difficult, as plasma phosphate concentrations do not necessarily reflect phosphate balance, and in some phosphate-depleted patients plasma alkaline phosphatase activity and parathyroid hormone concentrations may be normal. The position would be considerably helped by identification of the optimal predialysis concentration. This might lead to the avoidance of the two extremes of tissue calcification on the one hand and phosphate depletion osteomalacia on the other.

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¹ Baker, L R I, et al, *British Medical Journal*, 1974, 3, 150.
² Ahmed, K Y, et al, *Lancet*, in press.
³ Bishop, M C, et al, *Proceedings of the European Dialysis and Transplant Association*, 1971, 8, 106.

Inaccessible specialist

SIR,—With some difficulty I recently persuaded a young professional to seek psychiatric help for panic attacks. Because the consultant I wanted him to see was full-time, he attended the outpatient clinic at his local teaching hospital. There was a 3-4-week delay.

On arrival he was confronted by a student to whom he told his story with some diffidence and diminishing confidence. He was next confronted by the registrar, who in spite of protests insisted on a full repeat of the story. He was spared a third run because he was denied access to the consultant with whom a specific appointment had been made.

Obviously students have to be taught, but I doubt if this is the best way to encourage patient acceptance of psychiatry. But, much more important, why is it so difficult to see a specific specialist in the Health Service, or has the Service decided, like comprehensive education, to deny all choice? If so, why do they bother with specialists' names in clinics?

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Fetal transfusion syndrome

SIR,—Placental vascular anastomoses in mono-chorionic twins are not infrequent. However, they are usually fairly well balanced, so that neither twin suffers. The decision to perform an immediate blood transfusion in a severely anaemic "donor twin" or to bleed a "recipient twin" must be based on clinical judgment.

The following report seems to illustrate the above principle. In our unit a pair of mono-chorionic male twins were born via spontaneous vaginal delivery, each weighing 2.300 kg. Several hours later they did not

appear well. The first-born twin (twin A) was pale, tachycardic, and his haemoglobin was 11 g/dl and haematocrit 32%. The second-born twin (twin B) grunted and was plethoric and tachypneic. The edge of his liver was palpable 3 cm below the costal margin. His haemoglobin was 23 g/dl and haematocrit 69%. Their blood group was AB+.

We decided that both deserved treatment. We placed them one alongside the other, withdrew 35 ml blood through an umbilical vein from twin B, and transfused 30 ml of it through a peripheral vein to twin A. We used heparinised 10 ml syringes, and the procedure lasted about 15 minutes. Both infants improved almost immediately and seemed content. Their haemoglobins on the following day were 14 and 18 g/dl respectively.

To summarise, inequality of nature was corrected in an economic way and to the benefit of all parties involved.

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Carpal tunnel syndrome and tennis elbow

SIR,—May we thank Drs T C Beer and N Memon for the suggestions in their letter (31 July, p 299). We note with interest the figures of symptomatic tennis elbow in their series of cases of the carpal tunnel syndrome. In our series of patients reviewed after surgery for the carpal tunnel syndrome eight patients (18.5%) had previously sought medical advice on account of tennis elbow, and in five of these there was still clear evidence of tennis elbow when we saw them. A further six patients reviewed by us in this study had evidence of tennis elbow, making up our overall figure 14 (33%).

In relation to the second suggestion that our patients with carpal tunnel syndrome and our controls may not have been matched in respect of occupation, the figures in the table would seem to suggest that our two groups were in fact very comparable in this respect:

	Carpal Tunnel (43)	Control (43)
	Women (39)	Women (39)
Full time housewife ..	9	7
Office/clerical work ..	13	13
Light manual ..	13	16
(tailoress) ..	(8)	(5)
Moderate/heavy manual ..	2	3
	Men (4)	Men (4)
Light manual ..	3	3
Heavy manual ..	1	—
Unemployed ..	—	1

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Fear of ECT

SIR,—In the course of Professor W H Trethowan's irascible and contentious review of Dr Willis's new textbook of psychiatry (31 July, p 306) he makes several statements with which one might disagree. Most odd, however, is the passage in which, referring to the administration of ECT in pre-anaesthetic days, he describes patients who "would sometimes develop an inexplicable fear of it."