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Boy or girl—parental choice?

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Historical and archaeological evidence^{1,2} confirms that all ages and all societies have coped with the problem of selective preference for boys, and the need to limit their populations, by strategies that include simple infanticide, abortion, abstinence, adoption, and neglect. The practice of exposing alive the unexpected or unwanted child is a subject of considerable interest and controversy which recurs in the myths and legend of most, perhaps all, peoples.³

The following case history reveals and examines this phenomenon and the controversy it caused, initially among medical students at a general practice seminar and later among the medical staff who became involved.

Case report

A 30-year-old married Englishwoman (an only child) pregnant for the sixth time (para 3+3) threatened to kill both herself and the child of this pregnancy if the child was another daughter. The problem was presented to the general practitioner by her husband (also English), whose dilemma was how to deal with his wife's threat. The woman herself had agreed to the first two abortions and concurred in the need for the third—her husband wanted to buy a car. All three abortions had occurred before the "normal" birth of their two live girls, both now under 5 years old.

At a subsequent interview between the general practitioner and the wife she admitted to her feelings and requested an amniocentesis to determine the sex of the child, and an abortion if the fetus was not male. It was thought that the husband, despite his obvious dilemma, might also wish for a boy and thus be colluding with his wife. Whatever happened, it seemed likely that the woman would continue to get pregnant until a male child was born to them, thus sterilisation or contraception was out of the question.

The patient was introduced by the general practitioner to a "sympathetic" gynaecologist, who, after consultation with his colleagues, agreed to have an amniocentesis performed providing the

patient undertook psychiatric treatment. To this both husband and wife readily agreed. The result of the amniocentesis, performed at the 21st week of the pregnancy, showed that the fetus was female.

The prevailing medical opinion was that her request for an abortion on these grounds should be refused but that considerable support should be given to the continuation of the pregnancy together with an undefined offer of some help should a subsequent pregnancy occur.

She was delivered of a normal female child at 40 weeks by a caesarean section. Three months after the delivery mother and child are alive and well and the mother continues to receive psychiatric support.

Discussion

The demands that this woman and her family made on our medical expertise led us to question the basic social and biological factors which operate in our society and which provoked a seemingly intelligent woman to want to terminate a pregnancy for this reason. Furthermore, her demands led us to question her ability to care for her progeny of either sex now or in the future: do her live children require surrogate support? Nevertheless, the evidence is that she is an exemplary wife and mother.

A recent global review of the subject⁴ found that despite the emergence of female emancipation and the need to limit family size a preference for boys remains. In all communities "economic considerations for sex preference are minimal while psychological and emotional considerations have come to the fore"⁴—that is, anxiety about not having sons is evident. The review concluded that sex preference simply reflects the roles women and men have in society and conflicts with the humanitarian notion that every child is a wanted child and it questioned the status of women in society.⁵ Milton Freeman⁶ in his comments on the prestige, ethos, and economics of the practice of infanticide in primitive Eskimos regarded it as an evaluation of adult sex roles rather than a primary means of population control.

One must ask the question whether this woman's need for a son represented a similar interpretation of sex roles in our supposedly emancipated society or whether it was the surfacing of other primitive, complex feelings⁷ that men have about pregnancy and which should be looked for in counselling before and after termination of pregnancy and in antenatal care. It is interesting that such strong feelings, expressed by an articulate, aggressive woman who was diagnosed as requiring psychiatric care, were not only listened to but acted on.

New techniques for diagnosing fetal abnormality by amniocentesis may create entirely new attitudes. There is certainly

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evidence that there is an increasing demand for this technique, especially in the field of selective breeding.⁸⁻⁹ The uses to which amniocentesis may be put are wider than the medical purposes for which it was originally devised.¹⁰ In this case the decision taken was one where the general practitioner's suggestions carried no more weight than the woman's own request. Yet medically he had a much deeper knowledge of her circumstances and whether or not the pregnancy was desirable or not.

Although women are increasingly applying pressure for termination for social rather than medical reasons, the final decision for abortion is a medical one alone. In the last decade a more liberal¹¹ attitude has been apparent, and perhaps this patient's request was just ahead of its time. Nevertheless, it does raise the issue of abortion on demand with all its ethical and social implications, and the legal rights of all concerned.¹²

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SHORT REPORTS

Intestinal pseudo-obstruction in alcohol abuse: report of two cases

Acute intestinal pseudo-obstruction presents with the clinical features of bowel obstruction without any demonstrable lesion within the bowel lumen.¹ It is of unknown aetiology, but we report its occurrence in two patients with proved alcoholic liver disease and a recent history of alcohol abuse.

Case reports

(1) A 45-year-old man presented with 36 hours of abdominal distension, vomiting, and no bowel action for 72 hours. He had alcoholic hepatitis on liver biopsy one month earlier, when he had been dried out. He had subsequently relapsed to a level of one bottle of spirit daily. He had signs of intestinal obstruction with a distended tympanic abdomen and accentuated bowel sounds. There was no evidence of cardiorespiratory disease or a generalised systemic disease. Radiographs of the abdomen were consistent with colonic obstruction. Haemoglobin was 11.5 g/dl, white cell count $7.0 \times 10^9/l$ (7000/mm³). Plasma electrolytes were chloride 80 mmol(mEq)/l, bicarbonate 13 mmol(mEq)/l, potassium 3.2 mmol(mEq)/l, sodium 123 mmol(mEq)/l, urea 7.0 mmol/l, (42.0 mg/100 ml), creatinine 175 μ mol/l (1.92 mg/100 ml), and glucose 7.1 mmol/l (128 mg/100 ml). Liver function tests showed serum glutamate oxaloacetate transaminase 36 IU/l, bilirubin 15 μ mol/l (0.87 μ g/100 ml), alkaline phosphatase 96 IU/l, and gamma-glutamyl transpeptidase 435 IU/l. At laparotomy there was dilatation of the transverse colon but no demonstrable site of obstruction. A right defunctioning colostomy was performed. A barium enema later showed no abnormality. The colostomy was therefore closed, and he has made a good recovery off alcohol.

(2) A 79-year-old man presented with increasing abdominal distension, nausea, and no bowel action for 72 hours. Signs of chronic liver disease were present but the main signs were of acute obstruction confirmed by abdominal radiographs. Haemoglobin was 15.8 g/dl, WCC $9.6 \times 10^9/l$ (9600/mm³). Electrolytes were chloride 92 mmol(mEq)/l, TCO₂ 26 mmol(mEq)/l, potassium 3.9 mmol(mEq)/l, sodium 136 mmol(mEq)/l, urea 10.5 mmol/l (63 mg/100 ml), and creatinine 175 μ mol/l (1.92 mg). Liver function tests showed serum aspartate transaminase (AST) 52 IU/l, bilirubin 38 μ mol/l (2.2 μ g/100 ml). At laparotomy the main finding, apart from dilated bowel, was a nodular liver due to macronodular cirrhosis. It transpired that the man was drinking four pints (2.4 l) of beer and up to a further three measures of spirit a day. Postoperatively he developed increasing hepatic failure and died one month later.

Comment

Alcohol has numerous metabolic effects which may produce the syndrome of acute intestinal pseudo-obstruction. An increase in alcohol intake coupled with prolonged abstinence from food increases ketogenesis and a metabolic acidosis may occur, as in case I. Consequent disturbance of the acid-base equilibrium may inhibit gut motility. A similar mechanism may be implicated when pseudo-obstruction occurs in its reported associations of renal failure, pancreatitis, pneumonia, and congestive cardiac failure.¹ Alcohol may also act on gut hormones. Secretin and glucagon inhibit gastro-

intestinal contractions.² Alcohol ingestion causes a rapid increase in plasma secretin, possibly by a direct action within the duodenal lumen.³ Chronic alcohol ingestion by producing hypoglycaemia induces a secondary hyperglucagonaemia. This occurs in hepatic cirrhosis of any aetiology.⁴ The resultant increases in these hormones may combine to inhibit gut motility and hence pseudo-obstruction. This syndrome may be drug-induced, and has been reported with tricyclic antidepressants and phenothiazines.⁵ In reporting these cases Milner emphasised that alcohol may worsen the obstructive features by potentiating the parasympatholytic action of the drugs. Nevertheless, in neither of our cases could drugs be implicated. The association of alcohol abuse and pseudo-obstruction and the possible mechanisms involved need further study.

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Effect of depot medroxyprogesterone acetate on vaginal bleeding in the puerperium

If a woman becomes pregnant within two months of rubella vaccination there is a danger of fetal infection. Though the risk is probably small¹ a reliable contraceptive should be used. Depot medroxyprogesterone acetate (DMPA) has been recommended for this purpose in the puerperium.² Unfortunately, injectable progestogens may disrupt menstrual patterns and produce either irregular bleeding or amenorrhoea.³ This survey was undertaken to determine whether these side effects outweigh the convenience of giving DMPA to women requiring rubella vaccination in the puerperium.

Patients, methods, and results

Sixty patients who had puerperal rubella vaccination elected, after full discussion, to have a single injection of 150 mg DMPA. They were asked to record daily the amount of vaginal bleeding, to compare their blood loss with that after previous babies (multiparas) or menses before pregnancy (primi-