that break down in this way whether from intolerable outside pressures or inside strain. We must do all that we can as individuals and as a society to find that difficult balance between helping to preserve the integrity of the family while at the same time defending the children.—I am, etc.,

ALFRED WHITE FRANKLIN

London W.1

SIR,—Dr. Catherine S. Peckham and Miss Megan Jobling (21 June, p. 686), who considered the Registrar General's statistics for England and Wales on the deaths in children under 5, estimate that the number of fatalities from non-accidental injury "must be presumed to lie somewhere between 80 and 776 in 1972," probably "considerably nearer the lower figure than the higher."

They do not state what deaths are excluded from the tables entitled "Deaths in Under-5's from Non-transport Accidents," and "Suspected and Definite Non-accidental Injury," from which the figure 776 was derived. Their letter considers only one proposition: that an accident might not really be an accident. However, some diseases given as the cause of death may not be as innocent as the designation implies. Thirdly, the initial data as represented by their two tables are inadequate. They recognize this possibility, but only in a brief reference to other non-accident categories such as "sudden death (cause unknown)."

Parents do not always kill their children in convenient, easily ascertainable, dramatic ways which can be identified by pathologists and pigeon-holed in the accidental or non-accidental injury categories. I give the following examples. Deaths from inhalation of gastric contents in a child who may or may not be already ill. In some instances parents have permitted or encouraged young children to suffocate. Vomiting may be a precipitant of abuse or a consequence of abuse. Other examples include surreptitious repeated exposure; suffocation by pressing the baby's head against the sheets; deaths following intracerebral and subdural haemorrhages after shaking; deaths in spastics and severely subnormal children, from a multiplicity of causes, when the spasticity (or mental handicap) originated from a battering episode months or years previously; deaths from pneumonia, bronchitis, or bronchiolitis with previous indications of minor or major bruising or neglect. The above examples all occurred in known problem families with actively ill-treated and neglected young children.

Our own estimate,^{1,2} admittedly based on a study of a small population (200 000), was 300 deaths per year in England and Wales in the 0-3 group (by physical abuse), with a range within one standard error of 31 to 526, which is a similar range to that suggested by Dr. Peckham and Miss Jobling. Nevertheless, it would be a mistake to put an upper limit of 776 on the basis of the existing accident and non-accidental injury statistics. Other non-accident categories of death in childhood should also be seriously considered in the context of what else has been going on in the families concerned.—I am, etc.,

J. E. OLIVER

Burderop Hospital,
Wroughton,
Swindon, Wilts

- ¹ Baldwin, J. A., and Oliver, J. E. Submitted for publication.
- ² Oliver, J. E., et al., *Severely Ill-treated Young Children in North-east Wilts*. Oxford University Unit of Clinical Epidemiology, Research Report No. 4, August 1974.

Abortion (Amendment) Bill

SIR,—Dr. N. A. Chisholm writes (28 June, p. 748) that he is weary of reading letters on the "right of conscience" to abstain from giving medical help in abortion. Many would insist on the right and the duty to avoid terminating a particular pregnancy or taking steps likely to lead to a termination, but the duty to give medical help is implicit in the relationship between doctor and patient. It is very much more time-consuming to support a woman in distress with an unwanted pregnancy with counselling based on real Christian concern and compassion than it is to accede to her immediate demands for abortion. Those who have preserved women not just from back-street abortion but also from irresponsible surgical intervention have the satisfaction of knowing that they have also saved another life. Every woman has indeed a right to compassion and medical care in unwanted pregnancy, and every fetus has a right to be considered.

I believe that to talk as if an increase in abortion was caused by the Abortion Act is not nonsense. It is very difficult to believe that the enormous number of induced abortions since the Abortion Act became law has only replaced abortions which would have occurred anyway. It does not appear to have been proved that the Act has saved more mortality or morbidity than it has caused. It may have saved a small number of maternal deaths but at the expense of an enormous fetal mortality. The amount of physical and psychological harm done to women who have had abortions remains an unknown quantity but is not generally thought to be negligible. Surely therefore to equate medical care in unwanted pregnancy with abortion is a frightening oversimplification.

When the Abortion Act was passed my voice was not heard speaking against it. This was because it appeared to put on paper the indications for termination which were already accepted by many gynaecologists who were never prosecuted. It seemed to me logical that the written law should correspond with the law as administered. It was with surprise that I observed the Act's effects on my own patients. A number of pregnant women requested terminations when I knew that such a course would formerly have been against their principles. The Act had affected their consciences. Such is the responsibility the law-makers have. I shall not advise on the wisdom of James White's Bill as I was already proved wrong in my judgement of the original Act. But let those who make the law take care that the effect of their words is as intended.—I am, etc.,

M. B. H. WILSON

Woking, Surrey

SIR,—The Abortion (Amendment) Bill has received a second reading because of known abuse of the present law. The interests of the medical profession and the public at large will be better served if the Bill becomes

law. Some of the abuses have arisen because professional advice offered during 1967 was unheeded by the sponsors of the present Act. The Lane Committee was specifically barred from a full examination of the present Abortion Act, so its conclusions were incomplete.

In the part of the home counties in which I practise as a consultant gynaecologist abortion in early pregnancy is in fact available on request, contrary to the intentions of Parliament. This fact is so generally understood by both doctors and the public that my role as a gynaecologist is merely to determine whether the operation shall be done without fee or the patient referred to a clinic in the private sector of medical practice.

The protagonists of the 1967 Act strenuously denied that they were legalizing abortions on request. The medical practice at that time was codified with an additional clause permitting abortion in the likelihood of fetal abnormality. Unfortunately the code was badly worded: "continuance of the pregnancy would involve risk . . . greater than if the pregnancy were terminated." Since it can be shown statistically that in terms of the risk of death termination in early pregnancy for a healthy woman is a lesser risk than that of bearing a child, the legal case for abortion on request was established.

Doctors who decline to abort a woman in early pregnancy and who do not plead conscientious objection are liable to criminal prosecution under the current Act, and protagonists of abortion on request have been enabled to point an accusing finger at N.H.S. gynaecologists. Plainly the Lane Committee was correct in pointing out deficiencies in the N.H.S., since it is meant to be providing an abortion service in early pregnancy for all women. Are any women not "entitled"—to quote from your leader?

The middle ground in politics is always difficult to defend. The Abortion (Amendment) Bill merely seeks to reword the code using phrases such as "grave" or "serious" risk. Rather than constitute a threat to professional freedom, it would release doctors from the duplicity inherent in the present badly worded Act. It would permit prosecution of those doctors and others who have made legal abortion a scandal. No doctor who performed an abortion without fee in the wards of a public hospital or charitable institution would need to fear criminal prosecution.—I am, etc.,

G. S. BANWELL

Sawbridgeworth, Herts

SIR,—I have read with great interest the correspondence following your leading article "A Criminal Approach to Abortion" (17 May, p. 352).

I am delighted that you are allowing both points of view to be put forward, as a large number of medical practitioners, including myself, would welcome an amendment to the existing Abortion Law.—I am, etc.,

ANGELA M. H. LYNCH

Fleet, Hants

Abortion and Promiscuity

SIR,—I am having to examine an increasing number of young girls from the age of 12

who have had an abortion and been either fitted with an intrauterine device or issued with a contraceptive pill. They have been put on their sex-seeking path by their education in these matters and by films which would be regarded as pornographic or at least have an "X" certificate if shown in the public cinema. There has never been any medical or psychological reason for interrupting the pregnancy of these girls; it has merely been a matter of social convenience and often from the potential grandparents' point of view. The general attitude is that it is better to interrupt the pregnancy and destroy the life of the fetus than to interrupt the girls' schooling, in spite of the fact that by the time these girls have embarked on their sex-seeking they profit almost not at all from any further schooling.

The knowledge that they can obtain an abortion on demand and be issued with contraceptives is a great comfort to these promiscuous girls, who are grateful that they will not have to interrupt their sexual activities for long and that they will be made safe to carry on their practices. A pregnancy, though undesirable, at least keeps these girls away from their sexual activities for 30-40 weeks, perhaps longer. To put it very crudely, they have their belly full of sex and steer clear of it. During this time it is also possible to exercise control and augment the glandular changes by suitable training, so that the girl has an opportunity of being reclaimed. Aborting and fitting with contraceptives is the best insurance that these girls will continue with an even greater avidity on their promiscuous paths.—I am, etc.,

LOUISE F. W. EICKHOFF

Selly Oak Hospital,
Birmingham

Muscle Pain Induced by Exercise in Coxsackie Pericarditis

SIR,—Infections with viruses by the Coxsackie B group are known to be accompanied by myocarditis and pericarditis.¹ Particles resembling Coxsackie virus have been reported in ultrastructural studies of cases of dermatomyositis² and polymyositis,³ but there has been no clear correlation between myositis of voluntary muscles and Coxsackie infection in humans. Gatmaitan *et al.*,⁴ however, showed that mice infected with Coxsackie B3 developed a severe myositis of the hind limbs if forced to swim during the period of cardiomyopathy. Exercise also increased virus replication in affected muscle by a factor of 530.

No comparable studies have been reported in human Coxsackie infection, nor is it likely that any responsible clinician would consider undertaking them. It is therefore of interest to recount a personal experience of an experiment similar to that of Gatmaitan *et al.* In January 1975 I suffered from a typical attack of acute pericarditis. A previous episode in 1965 was shown to be due to an infection with Coxsackie B4, and the symptoms and clinical development of the disease were identical on both occasions. An E.C.G. taken shortly after the onset of pain showed ST-segment elevation followed by T-wave inversion in leads II and aVF, which later returned to normal. Four days after the onset of symptoms the chest pain was considerably easier and I undertook a series of vigorous exercises in an attempt to

expedite recovery by carrying out 10 press-ups at hourly intervals throughout the day. The effect, as with the mice, was dramatic. On the following day I developed severe pain and stiffness of the muscles of shoulders, arms, and trunk with tenderness, together with an exacerbation of the chest pain. A further two weeks of bed-rest were necessary before the symptoms subsided. The pain and stiffness were quite disproportionate to the amount of exertion, and I have frequently undertaken more exercise than this on other occasions with minimal after-effects.

I conclude that exercise undertaken in the course of a Coxsackie infection produced an acute myositis comparable to that described in mice. The unusual combination of circumstances involved in this human experiment may, I believe, justify its publication despite the absence of the controls and objective observations normally demanded by clinical science.—I am, etc.,

J. VERRIER JONES

Department of Medicine,
Southmead Hospital,
Bristol

- 1 Gear, J. H. S., and Measroch, V., in *Recent Advances in Studies in Cardiac Structure and Metabolism*, ed. E. Bajusz and G. Rona, vol. 2, pp. 141-163. Lancaster, Medical and Technical Publishing Co., 1973.
- 2 Chou, S. M., and Gutman, L., *Neurology*, 1970, 20, 205.
- 3 Mastaglia, F. L., and Walton, J. N., *Journal of Neurological Science*, 1970, 11, 593.
- 4 Gatmaitan, B. G., Chason, J. L., and Lerner, A. M., *Journal of Experimental Medicine*, 1970, 131, 1121.

Increased Serum Iron in Acute Leukaemia

SIR,—It is a little surprising that Dr. D. H. Parry and his colleagues (1 February, p. 245) make no mention of the studies we reported more than six years ago.¹ We found that 21 of 34 patients with acute myeloblastic leukaemia and two of six patients with acute lymphoblastic leukaemia had increased serum iron levels and markedly diminished or absent unbound iron-binding capacity.

We postulated that high serum iron and/or low unbound transferrin predispose patients with acute leukaemia to candidal infection by enhancing growth of this fungus. We described in-vitro studies supporting this hypothesis. We also suggested that the leukaemic cells might be the source of this increased iron, a suggestion which has now received added credence by the work of Dr. Parry and his colleagues.—I am, etc.,

FRED ROSNER

Division of Hematology,
Queens Hospital Center,
Queens, New York

- 1 Caroline, L., Rosner, F., and Kozinn, P. J., *Blood*, 1969, 34, 441.

Deaths in the Dental Chair

SIR,—Your report on the speech by Sir Rodney Swiss (24 May, p. 453) prompts me to say that I agree with him that modern conservative dentistry is very sophisticated. This therefore requires a co-operative patient, and for this type of work a sedated patient is the most relaxed to work on. In support of this the intravenous technique has developed.

Unfortunately there have been some

deaths in the chair, but reports^{1,2} show that the majority of these have occurred when there has been a consultant anaesthetist or doctor in attendance, so I cannot support Sir Rodney's view that dental surgeons, suitably qualified, with postgraduate training, and working in properly equipped surgeries to the guidelines laid down by Bourne³ are acting inexcusably. I was relieved to see that this is only the personal view of the speaker and not the general thinking of a learned body of men.—I am, etc.,

N. A. WAGNER

London W.4

- 1 Tomlin, P. J., *Anaesthesia*, 1974, 29, 551.
- 2 Bourne, J. G., *British Medical Journal*, 1973, 4, 611.
- 3 Bourne, J. G., *British Medical Journal*, 1967, 3, 616.

. A recommendation on this subject from the Standing Dental Advisory Committee has been circulated by the Chief Dental Officer to all dental practitioners (5 July, p. 51).—ED., *B.M.J.*

SIR,—With deep regret I report the death of a child whom I anaesthetized last month for another dentist to extract four deciduous teeth from the lower jaw. The patient was a healthy, intelligent boy aged 6. He was said to be nervous, but he did not seem so. He was placed semi-upright (45°) and given nitrous oxide, oxygen, and halothane by the Medrex method, using a full face-mask. Induction was quick and smooth, presenting no difficulty. After five breaths the nitrous oxide was stopped; he then had about 15 breaths of oxygen and halothane, after which he appeared to be satisfactorily anaesthetized. The mask was removed, the teeth were quickly and easily extracted, and the head was held forward for recovery. Almost immediately there were jerky movements of his legs, suggesting that he was coming round more rapidly than usual, but the next moment he became deathly white and stopped breathing. He was instantly put flat and his legs were raised, but he was pulseless and the pupils were dilated. From the start of induction to the cardiac arrest was less than three minutes. Cardiac massage and oxygen administration were started at once, and within 10 minutes two doctors were on the scene to help. They intubated the trachea and during the next few minutes there was some breathing of a sighing type, together with slight laryngeal reflex response. He was rushed to hospital where resuscitation attempts were continued, but to no avail.

My attention has been drawn to the two other dental deaths reported recently in your columns: those of a boy aged 10 in Lancashire (27 April, 1974, p. 224) and of a boy aged 13 in the Croydon district (11 January 1975, p. 93). In both those cases cardiac arrest occurred during recovery from brief inhalational anaesthesia administered by expert medical anaesthetists, and in both cases death was attributed to fainting. My case appears to be identical.—I am, etc.,

ALEN BRUNNEN

Faringdon, Oxon

SIR,—Sir Rodney Swiss (24 May, p. 453) and you in your leading article "Dental