It seems clear that the only spastic infant in our series would have been equally likely to be handicapped had it been delivered by caesarean section and, in our hands, prolonged resuscitation did not keep alive spasms caused by the mode of delivery, so depressing our perinatal loss rate. I thank Mr. E. O. Williams and Mr. S. S. F. Pooley for permission to follow up the patients referred to, who were under their care.—I am, etc.,

F. ANN MUSSON

Topsham, Devon

¹ Meeting of the Royal Society of Medicine, Obstetrics and Gynaecology Section, 30 May 1975.

² Neligan, G., et al., *The Formative Years; Birth, Family and Development in Newcastle upon Tyne*. Nuffield Provincial Hospitals Trust. London, Oxford University Press, 1974.

Adrenal Tumours and Hypertension

SIR,—We were interested to read the comments of Dr. V. Tchertkoff and colleagues (24 May, p. 444), though we have reservations in accepting their statement that adrenocortical nodules "have no relation whatsoever to hypertension." Others have described a higher incidence of such lesions in hypertensive patients compared with normotensives coming to necropsy.^{1,4}

All the patients in our series (18 January, p. 135) had hypertension with aldosterone excess. The pathological findings were as we reported. However, we did not conclude that the adrenocortical nodules in these patients had an aetiological role in either the hypertension or the aldosterone excess. Indeed, as previously reported,⁵ nodules were not identified in all patients, even among those in whom no tumour was found.—We are, etc.,

J. B. FERRISS
J. J. BROWN
D. L. DAVIES
R. FRASER

E. HAYWOOD
A. W. KAY
A. F. LEVER
J. I. S. ROBERTSON

Western Infirmary,
Glasgow

St. Mary's Hospital,
London W.2

¹ Dobbie, J. W., *Journal of Pathology*, 1969, **99**, 1.

² Symington, T., *Functional Pathology of the Human Adrenal Gland*. Edinburgh, Livingstone, 1969.

³ Neville, A. M., Mackay, A. M., *Clinics in Endocrinology and Metabolism*, 1972, **1**, 361.

⁴ Granger, P., and Genest, J., *Canadian Medical Association Journal*, 1970, **103**, 34.

⁵ Ferriss, J. B., et al., *Lancet*, 1970, **2**, 995.

Orbital Bruits in Patients on Maintenance Haemodialysis

SIR,—Referring to the investigation by Mr. S. R. Lancer and others (31 May, p. 481) of orbital bruits in patients on maintenance haemodialysis, we want to report an investigation we made of this subject.

We used the same method as Mr. Lancer and his colleagues. Two groups of patients were studied: 11 children on maintenance haemodialysis with an A.V. fistula and six children after renal transplantation with a still-functioning fistula. Their ages ranged from 5 to 17 years. All had a proximal and large A.V. fistula consisting of a saphenous loop inserted between the brachial artery and the cephalic vein. Seven of the patients on maintenance haemodialysis had an orbital bruit. After occlusion of the fistula the bruit

disappeared in one patient but appeared in two others without bruit with open fistula. The presence of the bruit was clearly related to the level of the packed cell volume. None of the patients with a functioning kidney transplant had an orbital bruit despite the presence of a large A.V. fistula. All patients had a packed cell volume greater than 35%.

We can endorse the importance of anaemia in relation to the appearance of an orbital bruit. The influence of the A.V. fistula is of less importance.—We are, etc.,

R. N. SUKHAI
R. A. DONCKERWOLCKE

University Children's Hospital,
Utrecht, Netherlands

An Easy Death—An Uneasy Argument

SIR,—Dr. M. A. Simpson's letter (19 July, p. 155) does indeed clarify the position in that he tacitly admits that good terminal care and active euthanasia are becoming synonymous. It only needs a breakthrough in consensus thinking, like that which made the Abortion Act of 1967 possible, to introduce "voluntary dying" as a respectable and accepted alternative to "natural dying" in circumstances defined by law. I introduce the subject of abortion because both abortion and euthanasia are expressions of active interference with natural processes to the denial of unwanted life—in the one case not yet born, in the other not yet concluded.

The frequency of suicide in dying patients is open to further study. One wonders how accurate are statistics in this connexion, since any compassionate doctor would record the killing disease as "cause of death" under such circumstances, not that the patient had stopped eating or breathing of his own accord. Other, more obvious methods would be beyond the strength of many terminal patients, though cases do occur of poor, distracted sufferers who have embraced death by more obvious means.

The diseases Dr. Simpson quotes are often associated with euphoria. For many people an organic disease is a relief from the unendurable tensions of life. It is when the disease has reached its terminal stage that the protracted business of dying has to be suffered to the advantage of none but simply out of deference to outworn conventions of the sanctity of life.—I am, etc.,

S. L. HENDERSON SMITH

Huddersfield

Increased Serum Iron in Acute Leukaemia

SIR,—We should like to correct Dr. F. Rosner's misconception (12 July, p. 100) regarding ferritin in acute leukaemia. Our paper (1 February, p. 245) was concerned only with serum ferritin protein concentrations. Ferritin is indeed an iron-containing protein and its concentration in the serum correlates well with total body iron stores in normal subjects. In leukaemic patients this relationship does not appear to exist, and in fact we found no correlation between serum ferritin and serum iron concentration.¹

In patients with acute myeloblastic leukaemia a gross rise in both serum and white cell ferritin concentrations was ob-

served but the white cell ferritin appeared to be mainly apoferritin²—that is, ferritin with very little iron in it. Furthermore, our preliminary studies on serum ferritin, at least in states of iron overload, show that it also is mainly apoferritin.²

We think it is important to appreciate the difference between serum iron (that is, transferrin-bound iron) and serum ferritin, especially in states such as acute leukaemia where the serum ferritin concentration probably bears little relationship to the iron stores of the patient.—We are, etc.,

D. H. PARRY
M. WORWOOD
A. JACOBS

University Hospital of Wales,
Cardiff

¹ Worwood, M., et al., *British Journal of Haematology*, 1974, **28**, 27.

² Worwood, M., et al., *Clinical Science and Molecular Medicine*, 1975, **48**, 441.

Infection after Insertion of I.U.D.

SIR,—The report by Dr. M. de Swiet and others (12 July, p. 76) of bacterial endocarditis diagnosed six weeks after the insertion of an intrauterine contraceptive device (I.U.D.) suggests that a causal relationship might exist and a recommendation is made regarding prophylactic chemotherapy. The bacteriological assessment of the case is admittedly incomplete and I suggest that the relationship was a causal one.

From 1964 I established a clinic at the Birmingham and Midland Hospital for Women where I.U.D.s were fitted to over 2000 patients whose immediate follow-up was excellent, though it lapsed subsequently. It has been a matter of surprise that clinical evidence of infection has been so trivial after such a comparatively unsterile procedure. No serious inflammatory complication that could reasonably be attributed to the I.U.D. has been noted. An exacerbation of pre-existing venereal infection was diagnosed in two patients. One woman developed gastroenteritis within 12 hours of fitting and the device was removed but refitted uneventfully afterwards. One patient evacuated a pyometra two years after fitting, but her uterine cavity was sterile and another device was fitted at her request. One patient was operated on for acute pelvic peritonitis two years after fitting, when the device was removed and bacterial swabs from it and from the pelvic peritoneum both showed haemolytic streptococci. Subsequent bacteriology, however, proved them to be of different types.

The successful use of the I.U.D. must depend largely on the astonishing resistance to infection of the endometrial cavity in the absence of pregnancy. I would like to emphasize my personal opinion, however, that an I.U.D. should be removed whenever possible as soon as any pregnancy should be diagnosed.—I am, etc.,

WILFRID MILLS

Birmingham

Metastatic Carcinoma Causing Haematemesis

SIR,—We were very interested in the description by Dr. E. Edward and Mr. G. Royle of a case of haematemesis due to gastric metastases from bronchial carcinoma (14 June, p. 598). We wish to report a similar case recently presenting with profound anaemia and widespread gastrointestinal

secondary deposits from a bronchial carcinoma.

A 66-year-old woman presented with a two-week history of weakness, breathlessness, and exhaustion. She had previously been a heavy smoker. There was no history of vomiting, haematemesis, or melaena. On examination she was very pale and breathless. Her pulse was 96/min, blood pressure 140/70 mm Hg lying, and she felt faint on sitting up. There was no finger clubbing. Some rhonchi and crepitations were heard in the chest, mainly on the right side. There was no abnormality on examination of her abdomen. Investigations showed: haemoglobin of 3.5 g/dl with a mean cell volume of 69 fl; pronounced anisocytosis and hypochromia; serum iron 6.6 $\mu\text{mol/l}$ (37 $\mu\text{g}/100\text{ ml}$); total iron binding capacity 80.5 $\mu\text{mol/l}$ (450 $\mu\text{g}/100\text{ ml}$); stool examination, occult blood positive; chest x-ray showed a mass in the region of the right hilum. A diagnosis was made of iron deficiency anaemia, exacerbation of chronic bronchitis, and a possible bronchial carcinoma. She was treated with blood transfusions and cotrimoxazole, but died five days after admission.

Post-mortem examination showed a mass 3 cm in diameter originating from the right main bronchus. On histological examination this was a squamous cell carcinoma. There was a 1.5-cm diameter deposit in the posterior wall of the cardia of the stomach, and this deposit had ulcerated. On macroscopic examination there were multiple ulcerated lesions scattered throughout the small intestine and deposits in the liver and the adrenal glands. The histological appearances of these lesions were similar to that of the bronchial carcinoma. We concluded that she had disseminated carcinomatosis from a bronchial carcinoma and that the intestinal deposits had caused gastrointestinal bleeding and anaemia.—We are, etc.,

K. E. GRAY
J. J. PATTEN

Barnet General Hospital,
Barnet, Herts

Stress in Families of Children who have Ingested Poisons

SIR,—Dr. J. R. Sibert (12 July, p. 87) is incorrect in stating that this problem has not been studied in Great Britain. We have been pursuing it for the last eight years.^{1 2}—I am, etc.,

J. A. KUZEMKO

Peterborough District Hospital,
Peterborough

- ¹ Julyan, M., and Kuzemko, J. A., *Practitioner*, 1972, 208, 252.
² Julyan, M., and Kuzemko, J. A., *Practitioner*, 1975, 214, 813.

Junior Hospital Staff Contract

SIR,—It has come to our notice that prior to the implementation date of the new hospital junior staff contract hospital junior staff in certain areas are being asked to sign forms stating their estimated units of medical time. Possibly this situation has arisen because of local misinterpretation of the implementation procedures agreed between ourselves and the departments of health. We felt that it may help to avoid misunderstanding if we explained the present position.

The agreed implementation procedures were designed specifically to obviate any

change in the pattern of work of the hospital junior staff and to maintain the quality of service to patients. The mechanisms for agreeing the average work load of a particular post (on which the new contract is based) are in the hands of the profession. Thus the organization of medical work remains the concern of the profession alone. The average amounts of time spent working and on call should be agreed between the junior or his or her consultant colleagues and then submitted to the employing authority for ratification. This exercise should not involve the junior staff signing any document which may be interpreted subsequently as a form of contract. Contracts will be issued to junior staff following completion of the pricing by the Doctors' and Dentists' Review Body. It will be at this point, provided a fair assessment of the work load of the post has been made, that an individual will enter into formal contractual agreement with the employing authority.

Those who have read the agreement reached with the Secretary of State in January 1975 (*B.M.J.*, 18 January, p. 159) will know that the new contract was designed to be fair to patients, employers, and the profession and to be flexible in operation.—We are, etc.,

D. BELL
Chairman,
Hospital Junior Staff Committee
J. A. FORD
Deputy Chairman,
Hospital Junior Staff Committee,
Chairman, Negotiating Subcommittee

B.M.A. House,
London W.C.1

Experience in General Practice

SIR,—I was interested to read Dr. B. P. Richardson's Personal View (28 June, p. 745). He demonstrates clearly the need for all doctors to undertake a trainee year in general practice. It is surely more important for those doctors who are going to spend their lives working in hospitals to have experience in general practice than for the future general practitioner. After all, he will eventually pick up some experience in the field. Most consultants have none. The poor service provided for many patients by consultants results not from lack of funds or time or facilities but from lack of understanding and ignorance of the patient's real needs and the general practitioner's capabilities. Two weeks during the clinical course and occasional locums are no substitute for a year's continuous experience. If consultants had such training a better service might result with far less wastage of scarce resources.—I am, etc.,

GILLIAN STRUBE

Crawley, Sussex

Points from Letters

Abortion (Amendment) Bill

Dr. W. LINDSAY NEUSTATTER (London W.1) writes: It is gratifying to see the stand the B.M.A. is making about the new Abortion Bill. Leaving aside the wider implications, it is most unsatisfactory that the very sensible phrase that the risks to the mother's life and health could be greater if

the pregnancy continued than if it was terminated, which allowed for clinical judgement of weighing the pros and cons, should be replaced by an exercise in semantics as to where "grave" and "serious" risks begin. Moreover, Lord Justice Ormrod pronounced that in diminished responsibility in murder it is for the doctor to say whether there is diminution and for the court to say if it is substantial. If the terms serious and grave are introduced the doctor may find himself in the unenviable position of having acted illegally should an action be brought in which the court did not concur that the condition was grave and serious. Or should he, with this fear in mind, hesitate to say a risk was serious, as a result of which the woman died or was very ill, he might find himself being sued for negligence. Moreover, surely any risk to life or health should be taken seriously. . . .

Dr. J. B. CLARKE (Wirral) writes: I wish to thank Dr. Isabel G. Smith and the Reverend J. B. Metcalfe (19 July, p. 160) for their honesty in being so explicit with their opinion that there is no ethical distinction between the prevention of conception and abortion. One may enter into debate as to when new life begins, but surely one cannot ignore the physiological fact of conception. The Revd. Metcalfe regards the issue as not being a moral one, but a political one based on what society will accept. If this is the ideology no doubt we can look forward to real progress in all issues of medical ethics. Medical ethics are the collective conscience of the profession. It is axiomatic of a profession that its ethical standards are decided by its members. A profession sets a standard of conduct for its members and the essence of professional freedom for a doctor is his right to act in professional matters uninfluenced by any consideration other than the judgement of his fellows. This principle would of course apply to both the 1967 legislation and current discussion of the amending Bill.

Dr. C. B. GOODHART (Cambridge) writes: The Reverend J. B. Metcalfe (19 July, p. 160) thinks that "it is the job of the legislators to specify an age after which abortion is deemed murder. This is not a moral decision but a political one based on what society will accept and what is enforceable." So if society accepted that to kill an unwanted full-term baby in utero was politically unobjectionable we need not bother about the morals of doing so. But why stop there? What about a few days after birth, or a few years? And what if it is the victim's race, religion, or politics which are unacceptable to the rest of society? . . . Whether or not abortion is properly to be called "murder" it certainly does involve killing. Sometimes this may be the lesser of two evils, as the Abortion (Amendment) Bill recognizes, when there is a risk of serious injury to the physical or mental health of the pregnant woman. But, though the decision on this may be a political one and the job of the legislators, it does not follow that a moral decision is not needed as well, in choosing the legislators to make sure that what they will find politically acceptable is also morally right.