Induction of Therapeutic Abortion with Urea

M. A. Pugh, F.R.C.S., and others

Endocrine and Metabolic Disorders in Bronchial Carcinoma

P. V. Wichert, M.D., and P. F. Mitchell-Heggs, M.B.

Screening for Breast Cancer

J. Gershon-Cohen, M.D.

Interaction between Phenytin and the Benzodiazepines

F. J. E. Vajda, M.R.C.P., and others

Infectious Mononucleosis

S. Talbot, M.R.C.P.

Small Drumsticks and Long Y Chromosomes

N. Ricci, M.B., and others

Induction of Therapeutic Abortion with Urea

Sir,—With reference to the article by Mr. J. D. Greenhalh and Mr. P. L. C. Diggory (2 January, p. 28) since March 1970 we have terminated 61 mid-trimester pregnancies where therapeutic abortion was required, using a hypertonic urea solution. Eighty grammes of urea, dissolved in 210 ml 5% dextrose (Ureaphil), was given by abdominal amniocentesis, the patients being given basal sedation with Valium (diazepam) 10 mg and Fortral (pentazocine) 30 mg intravenously and local anaesthetic to the skin. After urea instillation, the blood urea was measured at planned intervals for 24 hours to assess the rate of excretion.

In our experience, the induction-abortion delivery interval was so long that stimulation of labour with intravenous Syntocinon (synthetic oxytocin) was necessary. A high dose of Syntocinon was effective (50 u/1. of dextrose saline) and the infusion was given over four hours. It was reapeded on successive days if necessary.

Endocrine and Metabolic Disorders in Bronchial Carcinoma

Sir,—We are surprised at the high incidence of hypercalcaemia reported by Dr. J. G. Azzopardi and others (28 November, p. 528). Despite the by now well-established situaton of parathyroid activity often related to squamous cell carcinoma, in most cases it is very difficult to distinguish between hypercalcaemia due to bone metastases and that due to the endocrine disorder following excessive secretion of inappropriate parathormone. In our view it is impossible to differentiate between these possibilities using clinical variables alone without determining the level of parathormone activity. Unfortunately, not only is the estimation of parathormone activity difficult, but also bronchial carcinoma frequently metastasises to bone. Tumours which are large and have been growing for some time are frequently associated with clinically undetected bony metastases. Furthermore, there is no correlation between the size of a tumour or a metastasis and its biochemical activity. It is a characteristic feature of endocrine paraneoplastic syndromes that they are associated with small tumours; when these tumours produce hormones, the rate of production is excessive and is not related to the size of the tumour.

In a series of 300 cases of bronchial carcinoma which one of us (P.R.W.) has seen in Hamburg there have been no definite instances of hypercalcaemia due to paraneoplastic endocrinopathy. According to the literature which has been published to date, the incidence of paraneoplastic hyperparathyroidism is very low (7% of all tumour-related endocrinopathies).—We are, etc.,

Michael Pugh
Simon Khunda
Roger Baldwin

Royal Northern Hospital,
Holloway Road,
London N.7