the blood is achieved. However, in severe cases of pulmonary oedema flow rates of 20 l./min may be insufficient, so that severe and progressive respiratory acidosis develops. In such cases intermittent positive-pressure ventilation,[1] and in the most extreme cases continuous positive-pressure ventilation,[6] have been suggested. Rotating tourniquets may be used to produce a temporary reduction in ventricular filling pressure.

The acute form of pulmonary oedema is a medical emergency and presents a striking clinical picture. Laboratory measurements of respiratory and cardiac function and blood gas tensions may show gross abnormalities. It is not surprising that the improved understanding of its pathophysiology and the recognition that non-cardiac percipiating factors are increasingly important has led to a policy in some centres to admit patients with acute pulmonary oedema to intensive care units for immediate and close surveillance. Whether admission to such units is the best policy is still debated.

P. F. Griner[7] has reviewed the experience of adult patients admitted to a general hospital with a diagnosis of acute pulmonary oedema for the year before and after the opening of an intensive care unit. In both years the numbers of patients and their characteristics were broadly similar. Few patients had evidence of acute myocardial infarction (13%). After the opening of the intensive care unit 50% of the cases of acute pulmonary oedema which were referred were able to be accommodated. However, the mortality rate for acute pulmonary oedema was unchanged (8%), the duration of stay in hospital was longer, and the number of intubations doubled and was considered to be excessive at 40%. The number of blood gas measurements was five times greater than in those patients with acute pulmonary oedema treated in the general medical units. Though the patients were in the intensive care unit for only 26% of their hospital stay, the bills were 82% greater (average $3,448) than for those treated in the general medical wards ($1,893). Griner comments that the most noticeable change after the opening of the new unit was the increase in the cost of treatment, though he notes that other important factors such as patient comfort and satisfaction were not compared.

In the hospital under study these findings have led to a re-evaluation of the policy for the admission of patients with acute pulmonary oedema. After appropriate treatment in the emergency rooms, only exceptionally ill patients with acute pulmonary oedema are now admitted to the intensive care unit.

Despite the difficulty of making exact comparisons in such cases, Griner's findings are a salutary reminder that an increase in the number of investigations and the complexity of treatment does not lead automatically to a better outcome. The easy access to hospital under the Health Service in Great Britain, without direct cost at the time, should not be allowed to reduce the clear responsibility of doctors to evaluate at regular intervals the detailed management of different conditions.

[1] Robin, E. D., Cross, C. E., and Zelis, R., *New England Journal of Medicine*, 1973, 288, 239.
[2] West, J. B., in *Ventilation/Blood Flow and Gas Exchange*, 2nd edn. Philadelphia, F. A. Davis, 1970.
[3] Mason, D. T., Spann, J. F., Zelis, R., and Amsterdam, E. A., *Progress in Cardiovascular Diseases*, 1970, 12, 507.
[4] Mason, D. T., Spann, J. F., and Zelis, R., *Progress in Cardiovascular Diseases*, 1969, 11, 443.
[5] Zelis, R. F., Mason, D. T., Spann, J. F., and Amsterdam, E. A., *American Journal of Cariology*, 1970, 25, 136.
[6] Kumar, A., *et al.*, *New England Journal of Medicine*, 1970, 283, 1430.
[7] Griner, P. F., *Annals of Internal Medicine*, 1972, 77, 501.

# Facts about Abortions

One of the better features of the Abortion Act of 1967 was its provision that details of every termination should be notified to the Chief Medical Officer at the Department of Health. This has allowed the Registrar General to present periodic detailed analyses of abortion statistics, and the latest of these[1] deals with 1971, the first year in which over 100,000 terminations were carried out in England and Wales.

In all there were 126,777 operations in the year, of which 54,000 were in National Health Service hospitals. Nearly 95,000 were on residents of England and Wales and a further 2,000 on women from other parts of the British Isles. Almost all the 30,000 foreign women came from Europe, and of these 12,000 were French and 13,500 German; all ages were represented in this group with a shallow peak between 20 and 24.

Most of the tables deal with residents of England and Wales. Rather over half the terminations (53,000) were in single women and of these 43,000 had had no live-born children, while almost all were aged 24 or less. In contrast, all but 7,000 of the 42,000 married women had had two or more children, and most were aged 30 or above. Despite the marked differences in age and parity between the married and single women the rate per 1,000 women at risk showed little change from that at 16-19 (11·08) to that at 25-34 (10·4). Sterilization was carried out at the same time as abortion in 14,000 cases, including 343 in single women.

The two most common techniques were dilatation and curettage, used in 58,000 cases, and vacuum aspiration, used in 53,000, of which 45,000 were of less than 13 weeks' gestation. Abdominal hysterotomy was used in 11,000 cases and hysterectomy in another 1,000, mostly women aged 30 or over. There were 11 deaths: in six the termination had required either hysterotomy or hysterectomy, in three death followed vacuum aspiration, and in two the method was not specified. In only seven of the deaths was the abortion procedure thought to be directly responsible.

These bald statistics provide essential information while there is still so much controversy about the effects of the change in the abortion law, but they cannot help to answer the important question of the nature of the long-term physical and emotional sequelae of termination of pregnancy. This requires careful prospective studies by doctors working in the field, and there can be few more valuable topics for research.

[1] *Registrar General's Statistical Review of England and Wales for the Year 1971. Supplement on Abortion.* London, H.M.S.O., 1973, price 42p.