It is therefore suggested that these tests are not acceptable as indicators of abnormal metabolism of L-phenylalanine and L-tyrosine. —We are, etc.,

FLEMING CARSWILL.
Royal Hospital for Sick Children, Glasgow C.A.

I. W. DYMOCK.
King’s College Hospital, London S.E.1.

Prevention of Prolonged Labour
Sir,—I read with great interest and enjoyment the article under the above title by Mr. K. O’Driscoll and his colleagues in your issue of 24 May (p. 477).

Those of us familiar with the National Maternity Hospital will be aware that the practice of this institution reflects modern obstetric developments, and we believe the authors are to be congratulated upon their results.

For some years I have been a firm advocate of stimulation of labour both in private and hospital practice, and when proper supervision is exercised can confirm absolutely the desirability of this mode of management. However, my policy is not to attempt to produce any false labour by giving any drug. When I have to accouch a patient I occasionally am asked to make a warning note from points made in the opening preamble under the heading, "Three Popular Fallacies"? In my opinion prolonged labour, if allowed to occur, is still on occasion a reflection of at least relative cephalo-pelvic disproportion, and if in the course of a stimulated labour cervical stasis persists for four hours at most the case must be very carefully reviewed with a strong bias towards abdominal delivery. I have found that this policy has revealed a number of unexpectedly large babies whose future might well have been compromised by a difficult vaginal delivery had this been permitted to take place.—I am, etc.,

C. J. B. ORR.
Nassau, Bahamas.

Obstetric Practice

Abortion Act in Practice
Sir,—Dr. R. W. Penny (26 April, p. 248) and Drs. D. C. Sturdy and R. J. D. Browne (17 May, p. 447) raised the question of the ethical dilemma a second doctor may encounter when consulted by a woman whose general practitioner has refused to recommend her for abortion.

Few if any doctors would claim that in considering a request for therapeutic abortion they are able completely to divorce themselves from their religious, moral, and ethical beliefs and attain an objective and detached viewpoint. Inevitably the woman refused abortion by her general practitioner is likely to believe, even if mistakenly, that the refusal was based on such grounds. She is quite likely to feel a sense of aggrievement and resentment, and when, as is her undoubted right, she seeks a second opinion, she may state that she is unwilling to allow the second doctor to contact the first.

When a doctor is consulted in such a way he has three possible courses of action. Firstly, he may refuse to consider the case unless and until he has permission from the original general practitioner; an action which may be harsh and neglectful in the face of obvious and genuine distress. Secondly, he may insist on the patient writing and signing a declaration to him and to her original general practitioner that she is minded to change her practice forthwith, thus withdrawing from the list of her original general practitioners. Or, thirdly, he may agree to consider the problem but insist upon notifying the general practitioner of any decision he reaches. It is this last course of action which has offended Drs. Penny, Sturdy, and Browne, but the motive may well have included a desire not to deprive the colleague of a patient who is his own.

The whole dilemma can be avoided if all doctors who refused to recommend an abortion would make it perfectly clear to their patient that she is at liberty to seek a second opinion with his full approval.—I am, etc.,

G. J. DAVIES.
Nottingham.

Potassium Supplementation
Sir,—I am rather puzzled by the reference to "resin-based tablets" in the paragraph discussing potassium supplementation in the "Today’s Drugs" article on hypotensive drugs (17 May, p. 430).

The statement is made that "resin-based tablets may pass through the gut unchanged.

As a large proportion of potassium chloride tablets being used are present are the resin-based Ciba tablets known as Slow-K, and few, if any, resin-based tablets are in use, many readers might wrongly assume that Slow-K is in fact resin-based and, as such, liable to the problem referred to. Certainly there is no evidence of Slow-K tablets passing through the gut unchanged, although "ghost" cores consisting of the wax matrix may have occasionally been reported in the faces. It has, however, been clearly shown that the potassium in Slow-K is completely absorbed. 1 Analysis of "ghost" tablets has also shown that they have yielded up their potassium content in passing through the gut.—I am, etc.,

J. E. YARBOROUGH.
Ciba Laboratories Ltd., Horsham, Sussex.


"We regret that the use of the term "resin-based" was inaccurate."—Ed. B.M.J.

Points from Letters

Tetracosactrin
Dr. A. F. TAYLOR (Director, Medical Development, Organon Laboratories Ltd., Surrey) writes: May I draw attention to an omission from your useful article "Corticotropin and its Synthetic Analogues" (28 June, p. 809). Tetracosactrin is available in the United Kingdom as Cortrosyn and as a long-acting zinc hydroxide complex, Cortrosyn Depot. Cortrosyn is available in sterile ampoules each containing 0.25 mg from dried tetracosactrin. Cortrosyn Depot is presented in 2 ml vials containing concentrations of 0.5 mg/ml or 1 mg/ml.