whole subject will be discredited. Yet there is undoubtedly a core of findings which are important for understanding the control of autonomic functions in man and animals as well as for their potential clinical application. Clinicians should keep a keen but critical watch on this research—which may soon have something new and useful to offer their patients.

1 Di Cara, L., and Miller, N. E., Psychosomatic Medicine, 1968, 30, 489.  
4 Miller, N. E., Seminars in Psychiatry, 1972, 4, 3.  
10 Weiss, T., and Engel, B. T., Psychosomatic Medicine, 1971, 33, 301.  
14 Sargent, J. D., Green, E. E., and Walters, E. D., Psychosomatic Medicine, 1973, 35, 120.  
15 Sterman, M. B., and Friar, L., Electroencephalography and Neurophysiology, 1972, 25, 16.  

---

**Mid-Trimester Termination**

Many techniques formerly widely used for termination of mid-trimester pregnancies, such as intrauterine pastes and laminaria tents or bougies, have now been virtually abandoned because they are hazardous or unreliable or both. Intra-amniotic injections of hypertonic saline, glucose, or urea, while usually effective, may have dangerous consequences such as hypernatraemia or severe uterine sepsis.

In consequence for many gynaecologists abdominal hysterotomy has remained the technique of choice, despite its immediate and remote risks. During 1971 in England and Wales 10,960 pregnancies were terminated by abdominal hysterotomy (8.6% of all terminations), and five of the 11 notified deaths associated with termination followed hysterotomy.1 In Wales during 1969-72 more than a quarter (26.9%) of all terminations were by abdominal hysterotomy and four of the 3,139 patients died; three of them had previously been physically fit, while the fourth had heart disease and died from a pulmonary embolism.2

Now, however, prostaglandins seem to offer the most effective means of termination of pregnancy after 12 weeks’ gestation. The preparations at present available have drawbacks—rapid inactivation and a relatively high incidence of unpleasant side effects, especially of the alimentary system—when given by mouth, intravenously, or in the form of pessaries. Intrauterine administration overcomes some of the problems. Intra-amniotic injections are often used, but extra-amniotic (extraovular) infusion, either continuous or in divided doses, is more controllable and abortion commonly occurs within 24 hours. This interval can be reduced by one-third to a half by supplementary infusion of oxygen.3

Inevitably, the use of powerful stimulants of uterine activity must have dangers, and there are several recent reports of uterine rupture associated with the administration of intra- or extra-amniotic prostaglandins.4-8 In most cases the injury was a posterior cervical rupture. This problem does not seem specific to the use of prostaglandins, for similar trauma can occur in mid-trimester abortion by other techniques, including hypertonic saline, the introduction of soaps, and rupture of membrane.9-11 A striking feature of these cases is that the patient was almost all young primigravidae. Perhaps it is the patient rather than the technique which predisposes to this complication: resistance of the cervix to dilatation in primigravidae undergoing termination by suction aspiration or curettage is a common clinical observation.

These observations re-emphasize that mid-trimester termination is not a simple procedure, and that it carries major hazards. No matter which technique is used, termination should be undertaken in a fully equipped unit in controlled conditions and under specialist supervision. After mid-trimester abortion, it is prudent to carry out a speculum examination and to explore the uterus even though the abortion appears to be complete. Certainly prostaglandins should not be administered on an outpatient basis.

Earlier attendance by patients and better supporting services should lead to a decline in the need for late induction of abortion; but in certain circumstances the need may increase—for example, as the result of more widespread use of abortifacient fluid analysis and other methods of detection of fetal malformation. Methods for late termination of pregnancy should, therefore, be improved; and it seems that advances are most likely to come from refinement of techniques using prostaglandins and their analogues.

---

**Supraregional Assay Service**

The many new and technically complex analytical procedures introduced in the last decade have made it impossible for a single laboratory to provide a complete range of assays, especially since the steady rise in the routine workload has made full use of the existing facilities, often to near breaking point. Clinicians frequently find difficulty in obtaining certain hormone and other assays, to the detriment of their patients. In 1971 the Chief Scientist to the Department of Health and Social Security set up some working parties to advise on how best such assays could be provided. The American practice of increased reliance on commercial laboratories was ruled out on the grounds of cost and lack of accountability—though the accurate and rapid service provided by some of these laboratories demonstrated the practical advantages of centralization. The many diagnostic kits now available provide a cheaper