

necrotic that cortical damage becomes notable. Sometimes part or all of the necrotic papillae are cast off, but in other cases they remain in situ. In this event, cortical damage is more severe. Indeed, we have noted that when the papilla is shed leaving a sharp line of demarcation, as in the combination of infection and diabetes or of analgesic damage and infection, cortical damage may be remarkably slight. The determinant of cortical damage appears to us to be the degree of obstruction imposed by a necrotic papilla remaining in situ or by sclerosis at the line of separation.

Perhaps it is a matter of semantics, but we cannot agree that papillary necrosis is an acute lesion¹ and we wonder how it would be possible to identify evidence of *previous* damage in a totally necrotic papilla. However, though lines of separation can be seen in development, it is quite untrue that the tissue above the zone of total necrosis is entirely normal. In fact, it shows qualitatively similar changes, often with striking calcification in the necrobiotic tissue.

There is no logical basis for the suggestion that neoplastic change in the uroepithelium or stabilization of the patient's condition after cessation of analgesics indicates that renal papillary necrosis is not the sole primary lesion of analgesic renal damage.

It is extremely unlikely that the acute lesions produced by large intravenous doses of analgesics have any relevance whatever to the pathogenesis of analgesic nephropathy. The proximal tubule is, for obvious reasons, the segment of the nephron most vulnerable to toxic injury, but also possesses great regenerative powers. The lesion of human analgesic nephropathy produced by concentration of small doses of the toxic agent in the papilla has experimental^{5,6} and veterinary⁷ analogues.

In a prospective survey of some 2,000 necropsies collected over a year from early 1971 we were able to confirm previous findings.⁸ We could confidently identify numerous examples of subtotal analgesic damage and confirm that, in many of them, cortical damage was slight or absent. In the same study analysis of epidemiological data suggests very strongly that there has been a downturn in the incidence of analgesic nephropathy in Australia since 1968, attributable not to cessation of analgesic abuse, but to a diminished ingestion of phenacetin. This finding is in line with those of Murray⁹ and of Nordenfelt.¹⁰ If this is true, experimental work with rats using large doses of salicylate to produce papillary necrosis^{11,12} may prove also to be relevant to the problem of analgesic nephropathy. —We are, etc.,

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- 1 Nordenfelt, O., and Ringertz, N., *Acta Medica Scandinavica*, 1961, 170, 385.
- 2 Sanerkin, N. G., *British Journal of Urology*, 1966, 38, 361.
- 3 Burry, A. F., *Nephron*, 1968, 5, 185.
- 4 Schourup, K., *Acta pathologica et microbiologica Scandinavica*, 1957, 41, 462.
- 5 Levaditi, C., *Archives Internationales de Pharmacodynamie et de Thérapie*, 1901, 8, 45.
- 6 Davies, D. J., *Archives of Pathology*, 1968, 86, 377.
- 7 Salisbury, R. M., McIntosh, I. G., and Staples, E. L. J., *New Zealand Veterinary Journal*, 1969, 17, 227.
- 8 Burry, A. F., Axelsen, R. A., and Trollove, P. In press.

- 9 Murray, R. M., *British Medical Journal*, 1972, 4, 131.
- 10 Nordenfelt, O., *Acta Medica Scandinavica*, 1972, 191, 11.
- 11 Nanra, R. S., and Kincaid-Smith, P., *British Medical Journal*, 1970, 3, 559.
- 12 Axelsen, R. A., and Burry, A. F., *Pathology*, 1972, 4, 225.

Suppository Inserter: New Aid for the Disabled

SIR,—The patient who is disabled by rheumatoid arthritis suffers in many ways. His pain and stiffness are controlled by various methods, of which the administration of drugs in suppository form is one. The patient with deformity of his hands, frozen shoulders, or stiffened hip or knee may be given suppositories in hospital, where the nursing staff insert them, or at home, where the family, or district nurse is relied upon; many disabled patients indicate a reluctance to struggle to insert a suppository and embarrassment where family must be involved. Difficulties are also found in placing the suppository above the anal sphincter, and spontaneous expulsion may occur.

The instrument described here attempts to overcome these difficulties. The suppository inserter (fig. 1) is basically a U-tube with a "barrel" end-piece of larger calibre ($\frac{1}{2}$ in. (12.7 mm) in diameter). There is a flat plate

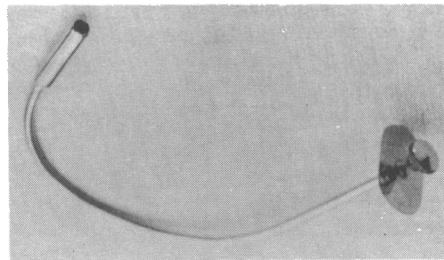


FIG. 1—Day's suppository inserter.

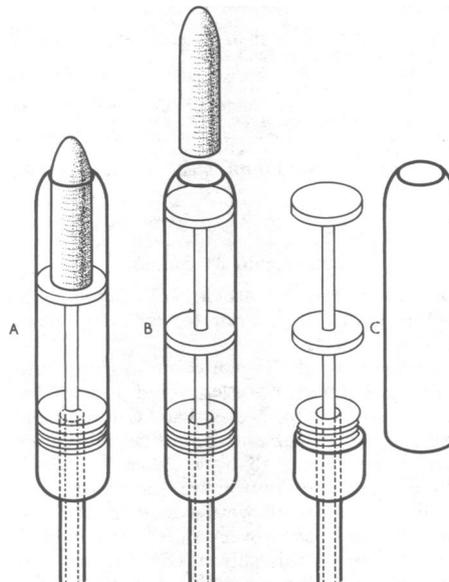


FIG. 2—Barrel end-piece. (a) Suppository in position (b) Suppository expelled. (c) Dismantled to show plunger and stop.

at the opposite end, large enough for clumsy fingers to hook round. A malleable wire traverses the tube; one end of the wire is fitted with a thumb piece; the other end, which terminates in the barrel, has two

plungers, one to expel the suppository and the other acting as a stop (fig. 2). The barrel end is long enough ($2\frac{1}{4}$ in.; 7 cm) to pass the anal sphincter when in situ and is removable for cleansing (fig. 2). The sweep of the tube is broad enough to suit all but the most obese patient and the resistance to the passage of the wire in the tube low enough to allow the piston to be operated with the minimum of pressure.

Thirty patients have used these instruments during one month; no difficulties were experienced in their use. Various positions were adopted to facilitate insertion, usually the left lateral position or standing was preferred. The technique recommended is to apply lubrication jelly to the end-piece, then slip a suppository into the end of the barrel. The "nose" of the suppository acts as an introducer. The end-piece, containing the suppository, is inserted into the rectum until the whole of the barrel is through the anus. The plunger is depressed and this expels the suppository above the sphincter, thus ensuring that it remains in place when the introducer is withdrawn.

The design of the instrument is such that variation in the bore of the barrel end-piece would allow any size of suppository to be used; it is envisaged that disposable end-pieces made in plastic will become available at a later date.

The appliance is manufactured by Hypodermic Services Ltd., Headlands Road, Liversedge, Yorks.

—I am, etc.,

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Abortion in 1972

SIR,—Mr. H. G. E. Arthure's careful letter (1 December, p. 549) emphasizes the very important fact that the earlier termination of pregnancy is done, the safer the procedure will be. He also calls attention again to the fact that hysterotomy is a far more dangerous procedure than vaginal termination. Following this Mr. Arthure says, "Meanwhile abortions after the first trimester should be done only if there is a danger to life or a serious risk of fetal abnormality." I feel that there is considerable danger in dogmatic statements, particularly should they influence the Lane Committee and possible future legislation governing medical practice.

I have just done a hysterotomy (my first for a very long time) on a girl who got pregnant shortly after her 11th birthday and whose pregnancy was discovered about 20 weeks later. There was no serious danger to her life nor of fetal abnormality, but I suspect that Mr. Arthure might well have acted similarly. I could give other examples of the difficulties which would be encountered if to much restriction is placed on the clinical judgement and freedom of action of doctors in the difficult field of abortion.—I am, etc.,

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Adoption Problems

SIR,—Between 1967 and 1971 there was a decrease of 40% in the number of infants offered for adoption through local authorities