abnormal (or even possibly abnormal) fetuses at any stage of pregnancy. I am particularly concerned that this may engender a change of attitude to the handicapped, somehow implying that they are less entitled to life than others.

Mr Victor Tunkel's legal analysis (p 253) is timely, but I feel that it would also be timely for all of us to look carefully into the moral question of abortion itself. Such a moral analysis may well give us the incentive to offer women the alternative of support and practical help throughout an unwanted pregnancy, and effective contraceptive advice afterwards.

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SIR,—Mr Victor Tunkel (28 July, p 253) points to some of the inconsistencies and absurdities in our abortion laws and appeals to the medical profession to exert pressure for reform. I would have more confidence that our laws might be realistic and responsive to the needs of the people they are meant to serve if legislators, doctors, and those enforcing the law listened to women rather than to themselves and to the rhetoric of intolerant bigots. I submit that, if they did, women would best be protected now by the repeal of all laws that make abortion a crime. Instead, I believe that the State should concern itself with the provision of the sort of abortion services that have been shown beyond reasonable doubt to protect the health of women. I am fed up with semantic arguments that ignore reality and with politicians, many of whom care more for their majority than for the health of half their constituents.

By concentrating on attempts to lower the legal limit for abortion your leading article in the same issue and some of your correspondents also miss the point. Mr John Corrie's Abortion Amendment Bill is going to affect far more women than would a reduction in the limit of viability. His Bill, by deleting the comparative clause in the present Act that allows the risks of abortion to be balanced against those of pregnancy continuing, together with the insertion of indefinable adjectives ("serious," "grave," and "substantial") to modify undefined nouns ("risks" and "health") could deprive up to 70 000 women each year of access to legal abortion. This provision would make a vast number of women even more dependent than they are now on the personal views, if not whims, of the doctors whose help they seek.

We profess to support sexual equality. But this can never exist while men, however noble their sentiments or erudite their arguments, ignore the right of women to choose freely whether or not they bear a child.

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SIR,—Dr Colin Brewer (11 August, p 389) wants your readers to have the pleasure—his taste in pleasure seems somewhat dubious—of pinning down anti-abortionists on the issue of the intrauterine contraceptive device.

I have a possibly heretical view that law ought to aim at keeping public order and preserving freedom, a view for which Dr Brewer may have little sympathy. However, Ms (presumably) Simms's letter in the same issue is an illustration of the callousness of the

pro-abortionist position, and might certainly arouse sympathy for the anti-IUD position as at least not lending support to the pro-abortion cause. One wonders how many decisions to use the IUD are not insufferably intolerant, as being a recommendation for people who are seen as incapable of controlling their fertility in any other way, made in the full knowledge that it is not reliable as a contraceptive anyway.

Perhaps Dr Brewer should be "made," to use his own delightful terminology, to state his own position on what he calls established human life. In what way is a fetus non-established—as opposed, for example, to a man on a respirator? The issues do not seem so clear cut as to allow the use of such coercive language as that of Dr Brewer. Perhaps also he might be invited to state his position on the morality, since he says abortion is a moral issue, of discrimination against would-be gynaecologists or others unwilling on conscientious grounds to perform, or assist at, abortions.

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SIR,—Dr Colin Brewer (11 August, p 389) is absolutely right. There seems little doubt that the intrauterine contraceptive device is abortifacient. Oral contraceptives also, besides preventing the production of fertile cervical mucus (contraceptive action) and inhibiting ovulation (sterilising action), interfere with implantation of fertilised ova by causing the endometrium to be out of phase (abortifacient action). Homicide should have no place in medicine, whether it be destruction of an embryo, fetus, infant, or adult.

I would go further. Mutilation, as practised in sterilising operations, and deliberate impairment of health, as when the endocrine system of the body is upset by oral contraceptives to impair fertility, should have no place in medicine. Such measures are inconsistent with the healing art. They are contradictory to our avowed purpose to promote health and prevent unnecessary loss of life. The medical profession has degraded itself by giving way to pressure to provide these "services." Some have gone only part of the way. Others have taken the road to its logical end—the destruction of human life on demand.

Is there an alternative? I think there is. Billings¹ has shown that women can be taught, through their mucus symptoms, to know their fertile and infertile times. Should we not as a profession be encouraging couples to have knowledge of and respect for their fertility? Would that not be constructive and positive rather than destructive and negative?

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¹ Weissmann, M C, *et al*, *Lancet*, 1972, 2, 813.

Rupture of the uterus during prostaglandin-induced abortion

SIR,—Although McKenzie *et al*¹ in their study in 1974 were unable to find in the literature a case of uterine rupture occurring as a complication of prostaglandin-induced abortion, several isolated cases have been reported since then,²⁻⁴ most recently by Dr Simon Emery and others (7 July, p 51). This complication has occurred only following intravenous or intra-amniotic administration of prostaglan-

dins. We now report a case in which uterine rupture occurred following the use of extra-amniotic prostaglandin E₂ (PGE₂).

The patient, aged 32, had had three previous vaginal deliveries at term and a spontaneous abortion at 12 weeks. An attack of rubella at 15 weeks was confirmed and termination of pregnancy was arranged at the 16th week. On admission, the size of the uterus was consistent with the period of amenorrhoea. A Foley catheter was introduced through the cervix into the extra-amniotic space and PGE₂ in solution, prepared in the usual manner, was instilled at a rate of 2 ml an hour. An intravenous infusion of oxytocin was commenced and after two hours the patient was having strong contractions. Twelve hours later vaginal bleeding occurred, at which time the patient's blood pressure had dropped to 95/60 mm Hg and her pulse was 120/min. On examination, a soft mass was found extending across the lower uterine segment, the uterine fundus being palpable above this at the level of the umbilicus. The cervix was dilated 4 cm. Uterine rupture was diagnosed and confirmed at laparotomy—it involved the right uterine artery, which was bleeding freely. After removal of the fetus, which had been extruded into the right broad ligament, subtotal hysterectomy was performed. The patient required seven units of blood and thereafter made an uneventful recovery.

Uterine rupture is a rare but sometimes fatal⁵ complication of therapeutic mid-trimester abortion, which has now been reported after prostaglandins administered by the intravenous, intra-amniotic, and extra-amniotic routes. We wish to draw attention to the fact that in most cases reported the patient also received intravenous oxytocin from an early stage in the procedure to facilitate abortion. We believe that early administration of intravenous oxytocin before prostaglandins have taken effect locally on the cervix may predispose to uterine rupture. In our unit therefore intravenous oxytocin is now used only after prostaglandins have been given for 12 hours, and then only if contractions are felt to be inadequate.

A I TRAUB
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¹ McKenzie, I Z, Hillier, K, and Embrey, M P, *British Medical Journal*, 1974, 4, 683.

² Propping, D, *et al*, *American Journal of Obstetrics and Gynecology*, 1977, 128, 689.

³ Borten, M, and Friedman, E A, *Prostaglandins*, 1978, 15, 187.

⁴ Smith, A M, *British Medical Journal*, 1975, 1, 205.

⁵ Grimes, D A, *et al*, *American Journal of Obstetrics and Gynecology*, 1978, 130, 591.

Lupus-type illness associated with labetalol

SIR,—We were interested to read the report of a lupus syndrome induced by pindolol, described by Dr J Bensaid and others (16 June, p 1603). We have recently seen a patient whom we considered to have a lupus-type illness, with strongly positive antinuclear antibodies, which was induced by another adrenergic blocking agent, labetalol, and which resolved on withdrawing the drug.

A 58-year-old white woman with a family history of malignant hypertension was found to have a blood pressure of 210/110 mm Hg in 1968. Renal function tests were normal and she was treated with methyldopa, initially alone and later with propranolol, from 1968 to 1976. From 1976 until February 1977 she received methyldopa and atenolol. She was then converted to labetalol only, initially 600 mg daily, increasing to 800 mg daily