a private abortion to the back street, with consequent maternal deaths.

M MARESH

Queen Charlotte's Hospital for Women,
London SW3 6LT

SIR,—Your leading article (28 July, p 230) raises the question of medical judgments "in good faith" and the inability of the law to challenge this. With the vast majority of British abortions in private and in some NHS practices carried out in healthy women at their request (since 1968 the total now approaching two million) one can understand MPs voting for reform by 242 to 98.

In 1967 Parliament did not intend to legalise abortion on demand, nor would a Bill in this direction ever pass a second reading. The problem for the future still remains a *moral* issue for patient, doctor, and nurse: should we ever destroy a potential or viable child except when there is no choice—the mother's life or health being at serious risk?

HUGH CAMERON McLAREN

Birmingham B15 2UP

SIR,—After reading Mr Victor Tunkel's article (28 July, p 253) on the present legal aspects of abortion, I am surprised that you can publish a leading article (p 230) entitled "No case for an abortion Bill." Whatever one's views on abortion, the following facts have to be faced.

Firstly, abortion is now socially and medically accepted by the majority. Secondly, owing to the wording of the 1967 Abortion Act, abortion on demand is legally feasible, but only at the whim of the consulted doctor. If he so wishes he can find, or *not* find, a clause to cover the termination of any pregnant woman. Thirdly, since 1967 it has been almost impossible for any doctor in this country to be trained or be appointed as a consultant gynaecologist unless he or she is willing to perform abortions. This form of conscientious and religious intolerance is a disgrace to the medical profession. It was only due to the vigilance of a few doctors that this did not also apply to anaesthetists. Finally, the 28-24-20 weeks' limit controversy is irrelevant. No doctor, however zealous, weak willed, or avaricious, wants to do late terminations and he only does them if driven into a medical corner from which he cannot escape.

There are therefore many legal and other reasons for an amending Act to the 1967 Abortion Act; whether the present one is the right one is another matter. The *BMJ* and the BMA should be considering this and giving a lead to medical and public opinion, not hiding behind "No case for an abortion Bill."

ROBERT LODER

Peterborough District Hospital,
Peterborough, Cambs PE3 6DA

SIR,—In your leading article (28 July, p 230) entitled "No case for an abortion Bill" you seem, in my opinion, to have failed to see the spirit of the law through dwelling too much on its letter. Despite its deficiencies, the Corrie Bill, I would submit, points in the right direction by demanding the necessity for grave medical reasons for abortion, rather than expecting the doctor to adduce reasons against the request if he feels such reasons exist (as is the situation under the Steel Act very much

endorsed by the recommendations of the Lane Committee). Requests for abortion often come from the anxious young but fully healthy woman, frequently little older in years and maturity than a child herself.

You rightly stress that the law must be flexible enough to take account of the rapid pace of development in antenatal diagnosis of genetic and developmental disorders. But on the other side of the scales, surely it should safeguard the sanctity of life of, to use your own words, the vast majority of normal fetuses by discouraging their destruction at a time when the woman's natural distress overrides her reason. If her parents, family, and social peers were to know that the law was more strongly protective, and that practical caring organisations such as LIFE long to offer help at this time, a different decision could often be taken and thousands of lives would be saved. Society and our profession could then be justly proud that a humane and positive advance had been made upon this present sad state of affairs.

MICHAEL E CARPENTER

Aldershot, GU11 3ST

SIR,—It is curious that your leading article (28 July, p 230) should argue that the Abortion (Amendment) Bill is "ill researched, ill conceived, and should be rejected," while at the same time commending Mr Victor Tunkel's article (p 253), which concludes that "the present state of affairs is highly unsatisfactory. . . . No one is sure what the law is."

The principal point in the Corrie Bill is to lower the gestation age above which there is a *prima facie* assumption that the child is viable from the present 28 weeks to 20. Everyone is agreed that nowadays, with intensive care, infants can and do survive premature birth from several weeks before the 28th. But there have been a number of well-publicised cases of late abortions involving babies showing signs of viability who, not being given proper care, later died: this was, of course, the whole object of the operation in the first place. With most of these gestation ages below 24 weeks had been assumed, but, particularly when the child was heard to cry, which implied that the lungs were inflated, it seems likely that the dates were miscalculated and that it was in fact viable. That being so, as Mr Tunkel rightly emphasises, it would have been fully, though ineffectively, protected under the Infant Life (Preservation) Act 1929, whatever the gestation age was supposed to have been.

Mr Corrie's Bill proposes a limit of 20 weeks because this is low enough (as 24 weeks is not) to ensure that genuine mistakes about viability are impossible. It could, perhaps, be argued that there are other reasons why 20 weeks is too low, sufficient to outweigh the risk of unlawfully killing viable babies, which are, anyway, unwanted. But not, surely, that it cannot be "shown that any of the recent headline stories of abortion scandals would have been less likely had the law been changed" in this respect.

C B GOODHART

Gonville and Caius College,
Cambridge CB2 1TA

Doctors and children's teeth

SIR,—I would like to make three points about your editorial comment on Dr Margaret Curran's letter (30 June, p 1794).

(1) A 2.2 mg sodium fluoride tablet is

equivalent to 1.0 mg fluoride ion and, to produce a concentration in solution of 1 ppm fluoride ion, the tablet should be dissolved in one litre of water, not two litres as you suggested. Indeed, the first sentence of your comment is ambiguous. The recommended dosages of 0.25, 0.5, and 1.0 mg are for fluoride ion, *not* sodium fluoride.

(2) From August 1978, manufacturers were required not to exceed 100 2.2 mg sodium fluoride tablets in a single container unless it was child-resistant. Under these circumstances, although mothers should always be advised to keep the tablets locked away in a medicine cupboard, it is highly unlikely that a child could put its life in danger by swallowing a large number from a container, although undoubtedly a young child could make itself ill.

(3) It is becoming apparent that the ingestion of fluoride once a day in tablet form is, in some respects, physiologically different from including a similar amount in the environment of the water supply. Because of this, some dental authorities are becoming more conservative in their dose levels. I think, in general, a more acceptable regimen in Britain at present would be 0.25 mg fluoride from birth to 2 years, 0.5 mg from 2 to 4 years of age, and 1.0 mg fluoride from 4 years onward. If the tablets are allowed to dissolve in the mouth, then their administration can be continued during adolescence as their topical effect on newly erupted teeth could be considerable.

Where the prevention of dental caries is critical—for example in high-risk, handicapped children—the dose level you suggest (0.25-0.5 mg fluoride ion up to 2 years and 1.0 mg fluoride ion afterwards) might still be recommended. In these cases the benefit of less dental decay easily outweighs the low risk of very mild dental fluorosis.

P J HOLLOWAY

Department of Child Dental Health,
University Dental Hospital of Manchester,
Manchester M15 6FH

Exophthalmos and pretibial myxoedema not responding to plasmapheresis

SIR,—The successful treatment of acute progressive exophthalmos and pretibial myxoedema has been reported by Dr P Dandona and others (10 February, p 374). We wish to report a case in which there was no clinical improvement as a result of plasmapheresis.

A 44-year-old woman presented with a five-month history, with symptoms and signs of thyrotoxicosis associated from the outset with pretibial myxoedema and exophthalmos. Initially her serum thyroxine (T₄), tri-iodothyronine assay (T_{3a}), and free thyroxine index (FTI) were raised: T₄ 156 nmol/l (12.2 µg/100 ml); T_{3a} 7.0 nmol/l (460 µg/100 ml); FTI 171%. The thyroid antimicrosomal antibody was positive at a titre of 1/1600, and thyroglobulin antibody was positive at a titre of 1/320.

The patient was treated with carbimazole, propranolol, and cyclopentiazide K, becoming clinically and biochemically euthyroid. However, her exophthalmos and pretibial myxoedema progressed. She was admitted to hospital for plasmapheresis, being given five exchanges over 10 days using a Haemonetics 30-cell separator. At each session from 1.2 to 2.0 l of plasma was removed and exchanged for a mixture of plasma protein fraction, isotonic saline, and anticoagulant citrate dextrose. Apart from temporary reduction of intraocular pressures on the day following the first exchange there was no improvement of the exophthalmos or pretibial myxoedema. During the course of plasma exchanges serum IgG levels