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

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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?

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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."

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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.

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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.

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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.

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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

assessed 48 hours after each exchange fell successively from 7.8 to 5.4 g/l.

Our failure to confirm Dandona's findings is unlikely to be due to any differences in the method used. Havard¹ states that plasmapheresis is effective only in acute and rapidly progressive exophthalmos; and although our patient's signs were progressive at the time of plasmapheresis they had been present for seven months, and one possible explanation is that irreversible fibrotic changes may have taken place.

If a circulating plasma factor such as an immunoglobulin is directly involved in progressive exophthalmos, some improvement in the eye signs should be expected following its removal by plasmapheresis. Individual variation in rate of synthesis and degree of tissue binding of any immunoglobulin is another factor that could affect the response to plasmapheresis. Nevertheless, the lack of response in our patient indicates that plasmapheresis is not a universally successful treatment of progressive exophthalmos.

In view of the variation in response to plasmapheresis in the two cases published to date, the place of this costly and potentially hazardous treatment of exophthalmos and pretibial myxoedema needs to be clearly defined.

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¹ Havard, C W H, *British Medical Journal*, 1979, **1**, 1001.

Fenclofenac-induced nephrotic syndrome

SIR,—Further to the review by Professor H A Lee (14 July, p 104) on drug-related disease and the kidney, we wish to report a patient with nephrotic syndrome secondary to fenclofenac therapy.

A 71-year-old woman was admitted for investigation in July 1978. She gave a three-week history of severe leg oedema and shortness of breath. Three years previously she had been diagnosed as suffering from rheumatoid arthritis, predominantly affecting her shoulders, hands, ankles, and feet. The latex test was strongly positive. In October 1977 she was started on fenclofenac, 300 mg three times a day. In November, one month after starting treatment, she was noted to have 7% eosinophilia (absolute count $0.4 \times 10^9/l$), with normal liver function tests. In April 1978 the dose of fenclofenac was increased to 1200 mg/day. Over the first eight months of treatment her urea rose from 5.4 mmol/l (32.5 mg/100 ml) to 15.1 mmol/l (91 mg/100 ml), and creatinine from 63 $\mu\text{mol/l}$ (0.7 mg/100 ml) to 143 $\mu\text{mol/l}$ (1.6 mg/100 ml). In June she developed proteinuria and oedema up to her sacrum. Fenclofenac was discontinued.

On admission she was not anaemic but was oedematous up to her mid-chest. Investigations revealed serum creatinine 136 $\mu\text{mol/l}$ (1.5 mg/100 ml), creatinine clearance 29 ml/min, urinary protein loss 4.70 g/24 hours, serum protein 41 g/l, albumin 19 g/l, and cholesterol 14.1 mmol/l (544 mg/100 ml). Differential protein clearance showed a selective proteinuria. Haemoglobin was 13.4 g/dl and ESR 83 mm in the first hour. A diagnosis of nephrotic syndrome was made. An intravenous urogram showed normal-sized kidneys with no evidence of obstruction. A renal biopsy showed mild focal proliferative glomerulonephritis. There was mild interstitial fibrosis but no arteritis or amyloid was present. The patient was treated with diuretics and, in view of the urinary protein loss rising to 7.9 g/24 hours, she was started on steroids (intravenous

prednisolone 128 mg/day for five days and then orally 80 mg/day). Her oedema settled, creatinine clearance improved, and urinary protein loss fell. Over the next six months her diuretics and steroids were gradually tailed off. In January 1979 her diuretics and steroids were discontinued. She remains well with no oedema, no proteinuria, and a serum creatinine concentration of 63 $\mu\text{mol/l}$ (0.7 mg/100 ml).

There has been one previous report of nephrotic syndrome in a patient taking fenclofenac.¹ No renal biopsy was performed. A complete recovery occurred on withdrawal of the drug. A hypersensitivity to alclofenac has been reported in three patients,² resulting in cutaneous vasculitis, mild proteinuria, and elevated serum urea. A renal biopsy in one patient showed focal proliferative glomerulonephritis with partial sclerosis of several glomeruli. It seems likely that our patient suffered a hypersensitivity reaction to fenclofenac resulting in eosinophilia and nephrotic syndrome, probably immune-complex mediated.

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¹ Smith, R B, *Proceedings of Royal Society of Medicine*, 1977, **70**, suppl 6, p 46.

² Billings, R A, et al, *British Medical Journal*, 1974, **4**, 263.

Gutter treatment for ingrowing toenails

SIR,—Mr W A Wallace and others in their recent article (21 July, p 168) state that the gutter technique may be the primary surgical treatment of choice for ingrowing toenails. They have reported a good symptomatic response with nail preservation, but a poor cure rate when compared with standard ablation techniques employed for recurrent ingrowing toenails. The gutter treatment must therefore be directly compared with simple avulsion of the toenail, at present the primary surgical treatment of choice for ingrowing toenail employed by numerous centres throughout the world. Mr Wallace's study, in which only 15 cases of simple avulsion are reported, fails to demonstrate that the gutter treatment has any significant advantage over simple avulsion, both methods of management having a reoperation rate of 33%.

Simple avulsion can be performed under local analgesia in over 90% of cases¹ with rapid symptomatic relief. The technique is no more complicated for the operator or distressful for the patient than gutter treatment and does not require the purchase of specially manufactured equipment. One hundred and thirty-eight out of 200 Glaswegian patients (69%) with an ingrowing toenail had both nail folds involved at presentation to hospital² and therefore would have required a gutter to be placed on both edges of the nail. This would prolong and possibly complicate the procedure, adding to the risk of failure due to the slipping of the gutter.

There is no theoretical reason why gutter treatment of ingrowing toenails should result in better long-term results than simple avulsion of the toenail, followed by conservative management of the new nail as described by Lloyd-Davis and Brill.³ A large randomised study is required to compare these two techniques and define their role in the primary surgical management of ingrowing toenails. Until the results of such a study are available

simple avulsion of the toenail should be retained as a useful technique in any toenail management protocol.

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¹ Murray, W R, *Clinical Orthopaedics and Related Research*, in press.

² Murray, W R, and Bedi, B S, *British Journal of Surgery*, 1975, **62**, 409.

³ Lloyd-Davis, R W, and Brill, G C, *British Journal of Surgery*, 1963, **50**, 592.

Hepatitis a cure for hay fever?

SIR,—I have read with great interest Dr John Morrison Smith's contribution on asthma under the heading "In My Own Time" (14 July, p 118) because my own experience has been very similar.

My first attack of hay fever was in the summer of 1916 when I was 10 years old. We had recently moved to London from Newcastle upon Tyne and during a game of cricket at my prep school I was afflicted with intense irritation of both eyes. Since this persisted and my eyes were obviously inflamed, the local GP was called in. He diagnosed my condition as "granular conjunctivitis." I was given some dark brown eye drops and the condition subsided after a few weeks. The following summer the same condition recurred and, in time, responded similarly to "treatment." The following winter I underwent appendicectomy, tonsillectomy, and adenoidectomy at the same time and had no more eye irritation until 1934, when this recurred during the summer while driving to Wales in an open car on my honeymoon. On this occasion I also had marked nasal congestion. A knowledgeable sister-in-law told me that I had hay fever, which would subside in the autumn. She was right. Since then I have been a regular sufferer from this complaint, complicated in moments of stress by symptoms of asthma—with characteristic sputum. For many years I have had desensitisation treatment without noticeable benefit.

Three years ago at the beginning of June, on my 70th birthday, I developed a febrile illness, which completely abolished my hay fever symptoms and which turned out to be infectious hepatitis. In spite of the high pollen counts during that very hot summer, and with all windows open to get some fresh air into the bedroom, I had no symptoms of hay fever that year; but these have since returned. It is interesting to record that two male relations (by marriage) used to suffer from hay fever but both were "cured" by an attack of "jaundice," and neither has had any recurrence since. Neither of them associated the cessation of hay fever with the previous attack of hepatitis. It might be illuminating to learn if such an occurrence is common.

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An ethical dilemma

SIR,—The BMA has recently issued a draft of a new edition of its handbook of medical ethics, which has been received with general approval. But one important matter involving an ethical dilemma is not even mentioned. I refer to pre-employment medical examination.