doctor at BPAS takes a full medical history, gives a thorough medical examination, sizes the pregnancy, and goes into the woman's reasons for seeking termination of pregnancy; he also discusses contraception with her at some length. If it is agreed that an abortion is legally to take place he takes from the patient a blood sample, which is sent in advance, along with her medical notes, to the BPAS clinic at which the operation will be performed. When the woman has arrived without the legal consent from a doctor she will see a second BPAS doctor quite independently of the first one. All this for £16.

As for Mr Corrie's talk of fee splitting, it was to prevent this sort of thing that BPAS, in the early days of legal abortion when demand far outstripped supply and some unpleasant practices grew up, decided to buy its own clinics as part of the same non-profit-making charity that ran the advisory centres in order to give continuity of medical care and prevent the need for women to pay doctors or clinics directly.

Those who, like Mr Corrie, believe abortion to be wrong have every right in a democratic society to try to outlaw it. But it seems to me that rights always incur duties: in this instance there should be a duty on those who attempt to enact legislation affecting the lives of others to understand the situation that exists and the situation they will bring about. Mr Corrie patently does neither.

DIANE MUNDAY

British Pregnancy Advisory Service,
Solihull, West Midlands B95 6DA

SIR,—We were appalled to read your leading article "Abortion—a matter of clinical judgment" (2 February, p 269), and have no doubt that many others were too. To have the whole heart of the problem dismissed as "moral and ethical overtones" is not only flippant but grossly offensive to those many doctors who see this problem as primarily a moral one. It is insulting to write that "the unanimous view of the medical experts" is against amendment of the 1967 Abortion Act. Does this mean that the BMA views any doctor, no matter how experienced or qualified, as ignorant if he thinks otherwise? This is clearly the view of Mr William Hamilton MP, who wrote in *The Times* on 2 February that "all responsible medical opinion" advises against the Corrie Bill.

The BMA is a professional body of the highest moral and intellectual standing, whose views carry great weight. It is surely its duty on a matter so crucial as the nature and morality of abortion to represent all views held by its members. It may well be that a majority of doctors would oppose the Corrie Bill, but it is an abuse of its moral standing if our professional association does not represent our views to our legislators with whom the final decision rests. If the advice circulated to all MPs is along the lines of your leading article then it is difficult to escape the feeling that a great professional association has descended to the level of the pressure groups of which it is so contemptuous.

DENIS DALEY
PAMELA LAURENCE
M O'KANE
T O'KANE

Morrison Hospital,
Swansea SA6 6NL

SIR,—Your leading article "Abortion: a matter of clinical judgment" (2 February, p 269)

states that "the law does not seek to dictate other clinical decisions that, like abortion, have moral and ethical overtones." You cite the freedom of doctors to withhold active treatment from severely handicapped babies and patients with incurable terminal disease.

But I argue that this is not a fair comparison with abortion. If the doctor were to take active measures to hasten the demise of his unfortunate patients with severe handicap or terminal illness then he would find that the law was very quick in expressing its disapproval of his actions. Such a clinical decision provides a much closer parallel to abortion.

The fact that the law has allowed abortion is not because it does not wish to dictate our clinical decisions, but because it has made an exception in the case of abortion.

PETER MANSON

Glasgow

SIR,—I should like to express my disquiet with the sentiments and assumptions of your leading article (2 February, p 269) and also with recent public statements and activities of representatives of the BMA concerning abortion. I regret that "most" doctors believe that early termination of pregnancy is usually justifiable in cases of contraceptive failure. I would like to know the facts on which this claim is made. You infer that abortion itself, a matter which probably most people in our community still regard very seriously, is no more than another operation, and therefore do you not rather presumptuously complain that MPs are concerning themselves with the significance of the operation?

To say that doctors are satisfied with the 1967 Act in that it works for both themselves and their patients is probably fallacious, and in any case puts forward a point of view that is parochial, shortsighted, and rather selfish in my view. Lastly, should the BMA actively represent the 1967 Act and itself to the public in a manner which may not have the support of the great majority of its members?

I support the Corrie Bill not only because I am opposed to abortion but also because the seriousness of the present situation and trend is at last acknowledged. Those practising what most people and doctors regard as responsible medicine, who see a threat in the words "serious" and "substantial," might reflect on the great numbers of unnecessary abortions that might be prevented by their supporting the Corrie Bill. The Bill would seem practicable or potentially so and given the present moral climate necessarily consistent with even a liberal morality. Its advantages far outweigh its disadvantages to my mind.

G C WILLIAMS

Darwen, Lancs

Exercise testing in peripheral vascular disease

SIR,—We read with interest the paper by Susan Laing and Mr Roger Greenhalgh on the use of exercise testing to assess peripheral vascular disease (5 January, p 12). However, we would take issue with them on several points. The authors report that walking a patient for one minute at 4 km/h on a 10% slope is acceptable to "both patient and doctor" since the patient is "no longer exercised to the point of claudication, and the

concomitant problems of shortage of breath and angina rarely occur during this period." This, unfortunately, misses several reasons for exercising the patient on a treadmill.

(1) Walking is the form of activity that produces the pain. Thus the treadmill enables us to ascertain the "actual" claudication distance, which the authors correctly state bears no relation to the patients' "claimed" distance.^{1,2} Patients are also all very different in their assessment of pain. To think that pain comes on at the same pressure in everyone and signifies that disease is present is an erroneous interpretation. One operates not only on the basis of a pressure drop, but also on the basis of symptoms.

(2) The degree of disability (pain) can be simply assessed and its localisation recorded. A function of the treadmill is to assess the degree of disability at the time of claudication, not at one minute. Thus if the fall in pressure is not consistent with the symptoms one may interpret a low pain threshold.

(3) It is possible to determine the degree to which the collateral circulation can maintain distal perfusion pressure at or near the point of maximal ischaemia. The authors state that "the pressure fall is the same whatever the period of exercise," but then contradict themselves in saying that the blood flow response is related to the amount of work performed. What the authors have found, in a limited number of patients, is that the level to which the ankle pressure falls after exercise is unaffected by the duration or intensity of the exercise as long as this exceeds one minute at 4 km/h. They state, rightly, that this finding contradicts those of Skinner and Strandness.³ However, examination of their work indicates that the patients they used had more severe disease than those examined in this study, and would therefore be expected to behave differently. We have tested 1959 patients and have recorded more than 9000 pressure response curves. Our findings support those of Skinner and Strandness and indicate that a stimulus of only one minute is not the best way to achieve consistent results.

(4) The time of recovery—that is, the period of postexercise hyperaemia, can be accurately determined. We have found that many patients recover their resting pressures within five minutes, indicating a good collateral circulation. This cannot be accurately assessed with a one-minute test. Such a short stimulus may be adequate to produce a maximum response in normal or mildly diseased vasculature, as suggested by the illustrations in the present article. It is certainly not adequate to produce a maximal response in patients with moderate and severe disease. That patients do recover quickly is good evidence that treating them surgically is unnecessary. Our figures indicate that, of the pressure response curves obtained from patients with symptoms of peripheral vascular disease, 35% are either normal or slightly abnormal, 47% have moderate disease, and only 18% indicate severe disease needing surgery.

(5) The presence of shortness of breath and angina are just as important as the claudication distance. Susan Laing and Mr Greenhalgh test their patients for one minute because "shortness of breath and angina rarely occur during this period." A vital bit of information is thus lost. If there is pulmonary insufficiency or angina this should be treated before the peripheral vascular insufficiency. We have several patients who were stopped not by claudication but angina. What these patients need is coronary arteriograms and, if necessary, bypass surgery. Only then should we decide on the need for peripheral arterial reconstruction.

In conclusion, we believe that the exercise test proposed loses much valuable diagnostic information. We believe that it is founded on a misunderstanding of the physiological processes involved and that its widespread use will lead to confusion. Our experience suggests that exercise to a maximum walking distance together with adequate classification^{4,5} of the postexercise pressure response curves gives far more information both for diagnosis and for evaluating the effects of therapy and the

progression of disease than does the one minute test.

W A P HAMILTON
P GAY
V C ROBERTS
L T COTTON

Biomedical Engineering Department,
King's College Hospital Medical School,
Dulwich Hospital,
London SE22 8PT

¹ Lorentsen E. *Scand J Clin Lab Invest* 1973;31:141-6.
² Thomas M, Quick LRG. *Br Med J* 1976;ii:1531.

³ Skinner JS, Strandness DE. *Circulation* 1967;36:15-22.

⁴ Gay P, Roberts VC. *J Biomed Eng* 1979;1:12-6.

⁵ Hamilton WAP, Wilton GN, Gay P, Stevens AL, Roberts VC, Cotton LT. In: Greenhalgh RM, ed. *Blood flow and pressure measurement in the management of aorto-iliac disease in smoking and arterial disease*. Tunbridge Wells: Pitman Medical (in press).

Dietary fibre and blood pressure

SIR,—Recent findings from our laboratory are relevant to the paper by Angela Wright and others (15 December, p 1541) on the effects of dietary fibre and polyunsaturated fatty acids. We reported a negative correlation between adipose tissue linoleic acid content (a long-term measure of linoleic acid intake) and systolic as well as diastolic blood pressure in a cross-sectional study of 800 randomly selected young German men.¹ This correlation was not attributable to age or weight differences.

It is our hypothesis that increased dietary intake of polyunsaturated fatty acids may result in both immediate and long-term increases in synthesis of the natriuretic prostaglandin E₂ via arachidonic acid. Indeed, dietary linoleic acid could be seen to be positively correlated with urine volume and sodium concentration and negatively correlated with serum sodium concentration in these men. The same mechanism of increased sodium excretion might apply to the effect of fibre as the stool weight increases by accumulation of water and electrolytes.

PETER OSTER
LENORE ARAB
BERNARD SCHELLENBERG
G SCHLIERF

Klinisches Institut für Herzinfarktforschung an der
Medizinischen Universitätsklinik,
D-6900 Heidelberg, West Germany

¹ Oster P, Arab L, Schellenberg B, et al. *Res Exp Med (Berl)* 1979;175:287-91.

The one-horse race at Moscow

SIR,—The International Olympic Committee has decided to go ahead with its plans to hold the 1980 Games at Moscow. Most likely the USA, West Germany, and the UK would boycott the Olympics because of the Russian involvement in Afghanistan. A number of other nations (Canada, Japan) may join the USA. It is of interest to evaluate the consequences of this partial boycott.

Over 130 nations participated in the Olympics held at Montreal in 1976. But only 13 nations won 10 or more medals. The distribution of medals (table) shows that in effect the competition is between two major power blocks. The two power blocks together won 520 (88%) of 591 medals.¹ Clearly if the leading contenders from one power block withdraw the games become a one-horse race.

Once every four years I raise my lone voice through your columns on the unfair rules of the Olympic Games.²⁻⁵ There is

Ranking in the Olympic Games (Montreal 1976) of 13 countries winning 10 or more medals within the major two power blocks

Power blocks			
I	No of medals	II	No of medals
Russia	125	USA	94
East Germany	90	West Germany	39
Rumania	27	Japan	25
Poland	25	UK	13
Bulgaria	24	Italy	13
Hungary	21	Canada	11
Cuba	13		
Total	325		195

already nothing international about the Olympics because of the serious nature of the height bias favouring the taller nations. With the exception of Japan, only four countries from Asia (Korea, Pakistan, Iran, and Thailand) could manage to win medals—only seven between them—and 31 of the 32 medals won by the Asian countries were either from the closed events (boxing, wrestling, judo, and weightlifting) or from gymnastics. It is not a surprise that the Japanese, despite their meticulous training, were unable to win a single medal in athletics, swimming, rowing, etc. I have also been advocating the urgency of some remedial action for reasons of health.⁶

I see a bleak future for the Olympics: its very survival is at stake as many other factors besides politics are likely to inhibit its continuation.⁷

T KHOSLA

Department of Medical Statistics,
Welsh National School of Medicine,
Cardiff CF4 4XN

¹ *The Times* 2 August 1976.

² Khosla T. *Br Med J* 1968;iv:111-13.

³ Khosla T. *Br J Prev Soc Med* 1971;25:114-8.

⁴ Khosla T. *Br Med J* 1976;ii:40-1.

⁵ Khosla T. *Br Med J* 1976;ii:471-2.

⁶ Khosla T. *Lancet* 1972;ii:1318.

⁷ Khosla T. *Br J Sports Med* 1977;ii:20-5.

Gastroscopic evaluation of anti-inflammatory agents

SIR,—I was intrigued to read the paper by Drs I Caruso and G Bianchi Porro (12 January, p 75) about the upper gastrointestinal endoscopy findings in patients who have been ingesting an assortment of anti-inflammatory agents. Their work accentuates the problems of assessing the effects of these drugs on the gastrointestinal tract. For example, visual assessment by endoscopy of mucous membranes is notoriously inaccurate even with the same operator as there are variables such as the angle of incident lighting, variation between individuals in the "redness" of the mucous membranes, and anatomical variations. In fact, double-contrast barium meal is as accurate as upper gastrointestinal endoscopy in detecting erosions and ulceration. Gastritis, however, presumably precedes these lesions and is a much more interesting and early lesion to detect.

The authors state the long-recognised fact that symptoms correlate poorly with signs in gastric (and duodenal) disease; but are we then to subject to endoscopy all patients who take possibly ulcerogenic agents? After all, one prescribes anti-inflammatory agents to relieve inflammation and pain and it is a calculated risk. On this point, there is no indication of the relative effects of these drugs on the joint symptoms for which, presumably, the patients had attended. Neither is there any indication of how many patients smoked, their ages, the severity of

disease process (and therefore the activity of the patients), or relevant past medical history—all of which may have predisposed to upper gastrointestinal erosion or ulceration.

It may be tempting to blame one drug (indomethacin) or exonerate another (sulindac) in being associated with gastric erosive lesions unless one considers the large number of variables, only a few of which have been listed above.

M S IRANI

Department of Biochemical Pharmacology,
King's College Hospital Medical School,
London SE5

SIR,—Drs I Caruso and G Bianchi Porro (12 January, p 75) have made an interesting study of the incidence of gastric lesions in patients with osteoarthritis or rheumatoid arthritis receiving anti-inflammatory drug treatment. Similar lesions are, however, seen in many patients without symptoms attributable to these lesions and without evidence of complications such as bleeding; and in view of the tremendous incidence of arthritis and the undoubted benefit conferred by these drugs, and the relatively low incidence of complication by haemorrhage, it does not seem likely that withdrawal of these drugs from such patients can be justified.

I would therefore be worried by their statement that the indiscriminate prescribing of anti-inflammatory drugs to patients with osteoarthritis is to be deplored. Indiscriminate prescribing is indeed to be deplored in itself, but the suggestion implied here is that the administration of these drugs to large numbers of patients with pain from arthritis should be curtailed. Surely a large number of patients would suffer as a result, although a very small number might be spared the complications of these gastric lesions.

JOHN KIRKHAM

St James' Hospital
London SW12 8HW

SIR,—We read with interest the article by Drs I Caruso and G Bianchi Porro (12 January, p 75) about a gastroscopic evaluation of anti-inflammatory drugs. We feel that this is a most important area in which to work because many rheumatology patients complain of dyspeptic symptoms and treatment may thus be hampered. The conclusions that these workers reach, however, are open to some question. Through your columns we should like to raise a number of points.

Drs Caruso and Porro report the finding of "gastric lesions" in 31% of patients with osteoarthritis and rheumatoid arthritis who were receiving anti-inflammatory agents. We are given no definition of these lesions. Furthermore, no biopsies were taken. Holdstock *et al*¹ have found that visual appearances of the mucosa gave a 16% false-positive rate and a 39% false-negative rate when the gastric mucosa was examined for gastritis. Photography is quite inadequate to give a firm assurance about the presence or absence of gastritis. We would suggest that to draw conclusions a firm definition of gastric lesions, together with histological support, is essential.

The gastric lesions may well be transient, and leave no evidence of their presence after healing. The significance of the lesions found in this study is therefore uncertain and in a selected group of patients frequent endoscopic examinations would be required to