other two patients had compound fractures and in both instances the brachial artery was severed. In each case the two ends of the artery were simply ligated and wound toilet was undertaken. In both instances the absence of a radial pulse is the only residual evidence of a vascular injury.

It appears, therefore, that Volkmann's ischaemic contracture may be the result of ill-advised bone manipulation when careful treatment of severe soft-tissue injury is the more urgent and important clinical problem. Dodge,² using a rather different clinical regimen, has similarly reported absence of ischaemic contracture in his series. Despite the persistent blame attached to supracondylar fracture for the highest numbers of contractures, our figures suggest that due care can eliminate the contracture from the scene.

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¹ Mubarak SJ, Carroll NC. *J Bone Joint Surg [Br]* 1979; **61B**:296-300.

² Dodge HS. *J Bone Joint Surg [Br]* 1972;**54A**:1408-18.

SIR,—I would like to amplify a point made by Mr Leslie Klenerman in his letter on Volkmann's ischaemic contracture (15 March, p 794).

In the experiments on laboratory animals referred to by Mr Klenerman Lundborg¹ showed that intraneural blood flow recovers completely after up to four hours' ischaemia; longer periods of ischaemia are followed by restoration of blood flow, but with increasing evidence of thrombus and embolus formation. Furthermore, when intraneural blood flow is restored oedema can be seen in the epineurial space after eight hours' ischaemia.

These findings emphasise the importance of early replant surgery following traumatic amputation.

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¹ Lundborg G. In: Daniel R, Terzis J, ed. *Reconstructive microsurgery*. Boston: Little, Brown and Co, 1977.

Abortion (Amendment) Bill

SIR,—The Guild of Catholic Doctors strongly deprecates the propaganda campaign which the British Medical Association launched against the recent Abortion (Amendment) Bill of Mr John Corrie, MP.

We accept that we live in a plural society and that the Association had been given a mandate by the 1978 Annual Representative Meeting to oppose any change in the 1967 Act. Nevertheless, since the Association claims to respect the conscientious views of all its members, we think it utterly wrong to have furthered this campaign, through the media and by letters to MPs, without giving any recognition to the fact that a substantial minority of members believes abortion to be morally wrong.

Such phrases as "The unanimous view of the medical experts" (2 February, p 269) fail conspicuously to acknowledge the point of view of those members who disagree. It is ironical that the same British Medical Association which opposed the 1967 Act at

the time should now describe itself to MPs as remaining "steadfast in its support for the existing 1967 Abortion Act."

We seek reassurance for our members and others that their conscientious views will not only be respected but will appear to be respected in the future.

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I JESSIMAN
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*.*The Secretary writes: "We hasten to reassure all those doctors who for ethical and religious reasons hold views contrary to those determined at the 1978 Annual Representative Meeting. In every field of medicine there is bound to be more than one point of view, and in correspondence—and indeed in quotations in the press—we have emphasised that our respect for minority opinions remains absolute. That respect, however, cannot alter our democratically determined policy."—ED, *BMJ*.

Pleural aspiration and biopsy

SIR,—May I rectify a serious omission in the recent article on pleural aspiration by Drs P B Iles and Colin Ogilvie (8 March, p 693)? Once the exploring needle has been advanced far enough to aspirate fluid it should be prevented from penetrating the chest further by clipping a strong artery forcep across its shaft flush with the skin.

Failure to take this simple precaution endangers the patient in several ways owing to the difficulty of keeping the needle immobile while manipulating a tap and syringe repeatedly, especially if the patient should cough or lurch back suddenly. As the needle moves between pleural space and skin the entry of bacteria and implantation of malignant cells is encouraged and, more seriously, penetration of a viscus is more likely with the needle free to move. The latter hazard is of particular importance when the diaphragm is elevated and is an anterior relation of the pleural space to a much higher level in the sitting patient than would be suspected from lateral radiographs taken during inspiration. I know of two cases where the diaphragm was known to have been penetrated; on one occasion the spleen was punctured and the patient became exsanguinated through bleeding into the left paracolic gutter; in the other case a pseudocyst of the pancreas was unknowingly tapped and leaked irritant fluid into the pleural space, causing considerable morbidity and diagnostic confusion.

Such complications can be prevented, and incidentally the maximum withdrawal of fluid can be achieved by immobilising the needle tip just within the pleural space in the manner described above.

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Evaluating urinary oestriol estimation

SIR,—Mr E J Shaxted's short report (8 March, p 684) concentrating on two out of 12 stillbirths in 1835 births is not really an adequate basis on which to assess the difficult question of the contribution urinary oestriol measure-

ment can make to reducing perinatal mortality. A recent survey of our own to be published elsewhere covered 626 perinatal deaths in 23 945 deliveries. No deaths attributable to chronic placental insufficiency were preceded by normal oestrogen values.

We agree with him that there is a world of difference between statistical and clinical significance; death knows no regard for two standard deviations from the mean. Predictions of risk can only be made in relation to information obtained when oestrogen concentrations have been found to be low, not acted upon, and the baby has died.¹

The arguments cannot all be expanded here but our experience leads us to the view that assaying 160 samples per week at a cost of about £0.90 per assay, equivalent to £2.00 per hospital delivery is money well spent.

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¹ Heys RF, Scott JS, Oakley RE, Stitch SR. *Lancet* 1968;**ii**:328-30.

Beta-blockers in immediate treatment of myocardial infarction

SIR,—In their excellently conducted trial of beta-blockers given early in suspected myocardial infarction (29 March, p 885), Dr R G Wilcox and his colleagues in Nottingham observed a mortality after six weeks of 8.1% in treated patients and 11.6% in controls. This difference was not statistically significant. They conclude that any difference which through chance they failed to detect "cannot be large enough to make a valuable contribution."

Clearly the authors, and perhaps many who read their conclusion, will now regard this particular question as closed. In fact, they observed a reduction in mortality of 30%; and their results are consistent, at the 95% confidence level, with a reduction of no less than 83%, or one life saved per 10 patients treated. Unfortunately in a study of this size a negative outcome proves nothing useful.

It is a pity, Sir, that editors do not follow the simple rule that authors should be required to report confidence limits in any negative trial. It might occasionally save a good treatment from premature dismissal.

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Indomethacin and perforated duodenal ulcer

SIR,—We have just read Mr M R Thompson's article on indomethacin and perforated ulcer (16 February, p 448). It seems to make an important mistake. Having noticed that a high proportion of women over 60 with perforated ulcer were indomethacin takers, the authors went on to compare their indomethacin consumption with that of a control group, who proved to have a lower indomethacin intake.

The author had no a priori reason to believe that indomethacin intake was especially frequent in women with perforated ulcer—he noticed an apparent oddity. To test if this meant anything he should have collected a