proved results, their criticism is potentially valid for any study taking place over a period of time. We agree with the Cardiff workers that the value of induction of labour should be tested in a large, prospective, randomised trial. In view of the conflicting opinions regarding the place of induction of labour we feel that such a trial would be entirely ethical. We would be grateful to hear from any obstetrician willing to co-operate in a multi-centre trial based on the model previously operated by Cole *et al.*¹

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¹ Cole, R A, Howie, P W, and Macnaughton, M C, *Lancet*, 1976, **1**, 767.

² Chalmers, I, *et al*, *British Medical Journal*, 1976, **1**, 735.

Effects on health of work in hospitals

SIR,—Many doctors will be aware of the possibility that abnormal patterns of health may be associated with different types of employment in medicine. The problems associated with working in operating theatres¹⁻³ are of particular concern to us and have resulted in a decision by the Department of Health⁴ that scavenging devices should be installed in operating theatres.

The Medical Research Council, in consultation with the Departments of Health and Employment, have agreed that there should be a five-year prospective study of the health of women doctors aged 40 years or less working in the hospital service in the United Kingdom. This study is designed particularly to investigate the effects of working in operating theatres, but information of more general interest is expected to emerge. Questionnaires will be posted in the next few weeks. It is hoped that all women doctors will appreciate the need for such an inquiry and that they will be willing to co-operate with us. The design of the inquiry ensures total confidentiality for all who participate.

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¹ Knill-Jones, R P, *et al*, *Lancet*, 1972, **1**, 1326.

² Knill-Jones, R P, *et al*, *Lancet*, 1975, **2**, 807.

³ American Association of Anesthesiologists, *Anesthesiology*, 1974, **41**, 321.

⁴ Department of Health and Social Security, HC(76) 38 or SHHD DS (76) 65, 1976.

Amendment of Abortion Act

SIR,—Caroline Woodroffe, Chairman of the Brook Advisory Centres, expresses (12 March, p 711) her "amazement [that] the opponents of abortion seemed put out in the House of Commons debate on 25 February because the absolute number of abortions is falling." Others might share her amazement, except that it wasn't so. Several MPs did indeed point out that too much should not be made of the claim that there had been an important fall in abortions for British residents, the decline from the 1973 peak being only about 10% and with no fall at all in the ratio of procured abortions to live births, to which the Minister could only reply that "starting from any baseline one can easily produce the

statistics one chooses" (*Hansard*, col 1806). But, although legal abortions now seem to be stabilising at around the really rather terrible figure of 100 000 a year, that *does* represent some significant fall in absolute numbers and there was nothing in the debate as recorded by *Hansard* to suggest otherwise than that this, so far as it goes, was welcomed by the supporters of Mr Benyon's Bill.

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Monitoring adverse reactions to drugs

SIR,—The Committee on Safety of Medicines regularly reviews the methods available for monitoring suspected drug reactions and has noted the recent discussions in the medical journals.¹⁻³ Several new schemes have been under consideration during the past two years for augmenting the present voluntary adverse reaction reporting system. Most of these would involve the identification of all or of a substantial proportion of the patients who receive newly introduced medicines. Any such scheme would inevitably have far reaching consequences for the professions, the pharmaceutical industry, and the Health Departments. Consultations with the professions, pharmaceutical industry, and other interested parties will begin in the near future.

ERIC SCOWEN

Chairman,
Committee on Safety of Medicines

London EC2

¹ *Lancet*, 1976, **2**, 1312.

² Dollery, C T, and Rawlins, M D, *British Medical Journal*, 1977, **1**, 96.

³ Lawson, D H, and Henry, D A, *British Medical Journal*, 1977, **1**, 691.

"Abortion on demand"

SIR,—Now that the excitement surrounding the second reading of the Benyon Bill has died down perhaps I can calmly reintroduce the interesting question of the meaning of the phrase "abortion on demand."

Professors G W Theobald and H C McLaren (26 February, p 575) confirm my belief that the phrase does not have a single meaning but means different things to different people. Professor Theobald suggests that "abortion on demand" has the same meaning as allowing abortion if the woman "feels sure that it is a better course of action than continuing the pregnancy." Professor McLaren, on the other hand, prefers to call this by the less emotive phrase "abortion on request." Others understand "abortion on demand" to mean much more than this and in particular that any woman demanding an abortion should be given one (a) without inquiry as to *who* is doing the demanding—the woman or her boyfriend, mother, or husband—and (b) whatever the views of the doctor involved, who may be expected to perform the abortion against his or her will. Not surprisingly such an interpretation raises the hackles of many doctors, wherever they stand on the abortion issue. Yet to say that one believes in "abortion on demand" without further explanation is to allow this interpretation of one's beliefs. Quite understandably, Professor A W Beard and Mr D B Paintin (12 February, p 448) would prefer to be more precise in describing their belief as "abortion should be performed at the request of the woman

once she has had adequate counselling."

Professor Beard and Mr Paintin are not alone in their difficulty nor in their beliefs. "Doctors for a Woman's Choice on Abortion" is a group of nearly 400 doctors who believe that any woman who requests an abortion, having considered the alternatives, should be able to have one. The group also believes that every woman who requests an abortion should have access to unbiased counselling; the group does not believe that any doctor should be expected to perform an abortion against his or her will. Are we advocating abortion on demand? Or perhaps it is abortion on request? The answer depends on definitions. But what we *are* advocating is a woman's right to choose on abortion and this is surely *not* open to misinterpretation.

Unless it can be shown that the phrase "abortion on demand" has some advantage over more precise descriptions of attitudes and belief let us avoid the phrase and persuade and encourage journalists and opinion polls to avoid it likewise.

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Dangers of dextropropoxyphene

SIR,—We believe that your recent leading article (12 March, p 668) is a further timely reminder of the potential seriousness of dextropropoxyphene poisoning. Surprisingly, however, no mention was made of the fact that the cerebral and the cardiorespiratory depressive effects that may follow an overdose of dextropropoxyphene can be prevented or abolished by naloxone.¹⁻³ Repeated doses of this safe and specific antagonist may be required as the duration of action of dextropropoxyphene exceeds that of naloxone.

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¹ Kersh, E F, *Chest*, 1973, **63**, 112.

² Tarala, R, and Forrest, J A H, *British Medical Journal*, 1973, **2**, 550.

³ Lovejoy, F H, *et al*, *Journal of Pediatrics*, 1974, **85**, 98.

Takayasu's arteritis

SIR,—Your leading article (12 March, p 667) on this rare and interesting disease referred to sparse reports from Britain and to the scanty information on the effectiveness of steroid therapy. You may therefore be interested in a brief case report of a patient who has been observed from the onset and recovered with steroid therapy; she is still well 20 years later.

A woman aged 24 was admitted to hospital in 1957 with a subacute illness of several weeks' duration complaining of malaise, generalised aches, and right pleural pain. Clinical examination: pyrexia; radial pulses palpable but reduced; blood pressure 120/80 mm Hg; right pleural friction. Chest x-ray: mottling in right lower lobe with enlarged right hilar node. Laboratory tests: blood count normal except for anaemia (haemoglobin 66%); erythrocyte sedimentation rate 56 mm in 1 h; tuberculin skin test negative at 1/1000; antibody titre to psittacosis positive 1/40 but no change over next 12 weeks; LE cells not detected;

Widal reaction negative; C-reactive protein ++; antibodies to influenza negative; serum proteins normal. Primary pulmonary tuberculosis was suspected so she received a trial of streptomycin, PAS, and isoniazid. There was only a slight improvement and the pyrexia persisted.

Three weeks later she complained of giddiness. No neurological signs were elicited but it was observed that neither radial pulse was palpable. The brachial pulses were absent and the axillary and carotid pulses very weak. The blood pressure could not be registered in either arm; the skin was cold but not gangrenous; she complained bitterly of pain in the arms and over the chest and back. The eyes were normal. A diagnosis was made of "pulseless disease," probably autoimmune in origin.

Streptomycin and chemotherapy were discontinued and replaced by steroid therapy (prednisolone 7.5 mg daily). Improvement was gradual. The pyrexia subsided and the chest x-ray cleared, but she continued to complain of pain in the arms, especially on movement, and arterial pulsation in the upper extremities remained absent for several months. In 1960, after three years' steroid treatment, all the arterial pulses in the upper extremities could be palpated easily and the carotid pulses were normal; the blood pressure was 120/80 mm in each arm. A systolic murmur was audible in the neck on both sides. Tests for antinuclear factor were now strongly positive. In 1963 an aortogram showed a normal arterial tree except for narrowing of the left subclavian distal to the first rib. After six years steroid treatment was reduced gradually over a period of four months. This was associated with recurrence of pain, especially in the arms, neck, and back, with Raynaud's phenomenon, and when the treatment was discontinued a rash appeared on the legs akin to erythema nodosum. Biopsy showed a lesion indistinguishable from lupus erythematosus; LE cells were now detected for the first and only time. The pulses remained normal. In March 1965 steroid treatment was started again. The skin lesions and pain gradually resolved. Any attempt to reduce the dose of prednisolone below 7.5 mg daily caused pain. For the past 12 years steroid treatment has been continued in a daily dose of 7.5 mg and she has remained reasonably well; the arterial pulses in the neck and upper extremities have remained full. Twenty years after the onset she continues to lead a full life as housewife and secretary.

In this case the aetiology seems to be systemic lupus. Not only has steroid treatment resolved the obstructive arterial lesions but it has probably prevented ocular complications.

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Acquired myopia and educational attainment

SIR,—There may be no real mystery about the apparent association between acquired myopia and educational attainment. In their careful report (26 February, p 542) Dr Catherine S Peckham and her colleagues rightly point out the genetic nature of this defect. It requires no Mendelian genius to deduce that a myopic trait without some other compensatory advantage would be a severe handicap to family expansion and support in a peasant society or in manual occupations. It is tempting to speculate that in Catholic societies even the clever myopic trait was denied breeding by feeding its possessors into the priesthood. At a guess it seems not unlikely that an epidemiological investigation at the other end of the scale, the multiply handicapped, would also show an apparent increased prevalence of myopia. In these cases transmission is unlikely.

As long as society does not introduce some

artificial restraint on the progress and breeding of individuals with some disadvantage such as excessive shortness, hirsutism, or skin pigmentation compensated gifted families with these traits will prosper. Unfortunately society is not usually so tolerant. Myopia gene carriers may well consider themselves fortunate to possess what would be a great handicap in a primitive society but which in the technological age finds not only occupation but benefits from an aura of intellectualism. Even in this age, however, the myopic conquerors must still be bright to benefit.

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Cardiomyopathy in uraemic patients on long-term haemodialysis

SIR,—Dr Tilman Drücke and others (5 February, p 350) have presented convincing haemodynamic evidence of a congestive cardiomyopathy developing in three patients undergoing regular haemodialysis.¹ Their data on two other patients with ventricular dilatation, decreased index of normalised rigidity, and normal ejection fractions suggested that the process initially affects cardiac rigidity. This change, however, may simply reflect a compensated chronic volume overloaded state. We have studied a dialysis patient with a severe cardiomyopathy in whom clinical and haemodynamic parameters improved following successful renal transplantation.

A 34-year-old, non-hypertensive, non-alcoholic White male developed end-stage renal disease secondary to complications of cystinuria. He began haemodialysis in 1973 and experienced multiple bouts of congestive heart failure starting early in 1974. Treatment consisted of ultrafiltration dialysis for 4 hours 5 days a week and digitalis. In April 1975 he underwent pericardial stripping after developing tamponade. The myocardium was described by the surgeon as contracting poorly. The patient underwent cardiac catheterisation in October 1975 because of continued severe exertional dyspnoea, fatigue, and paroxysmal nocturnal dyspnoea.

Left ventricular hypertrophy was noted from the ECG voltage and chest radiographs showed four-chamber cardiac enlargement with increased pulmonary vascularity. Physical examination revealed 1+ oedema, hepatomegaly, jugular venous distension without Kussmaul's sign, biventricular enlargement, increased pulmonary second sound, and loud S₂ and S₃ gallops. Left and right heart catheterisation revealed: normal blood pressure, reduced cardiac index (2.4 l/min/m² by dye dilution when haematocrit was 30%), reduced stroke index (28 ml/beat/m²), elevated left ventricular end-diastolic pressure (24 mm Hg), reduced ejection fraction (0.23), and no haemodynamic evidence of constrictive disease. There was marked ventricular dilatation and diffuse hypokinesis with mild mitral regurgitation. A 50% stenosis of the left main coronary artery and another 50-60% lesion at its bifurcation were noted.

A non-living donor renal transplant was performed in November 1975. In April 1976 the patient underwent a limited haemodynamic assessment. His haematocrit was 40.5% and serum creatinine 168 µmol/l (1.9 mg/100 ml). Medications included azathioprine 50 mg, cyclophosphamide 75 mg, and prednisone 10 mg daily; diuretics were stopped five days before the study. Heart size had markedly decreased, exercise tolerance was much improved, and his dry weight had increased by about 15 kg. Blood volume was elevated at the time of study, intra-arterial blood pressure was 137/60 mm Hg, and cardiac and stroke indices were 4.34 l/min/m² and 46 ml/beat/m² respectively.

Our patient's clinical course before transplantation differs from that of Bailey's group of severely uraemic patients who improved after initiation of dialysis.¹ One cannot rule out a favourable effect of corticosteroids on myocardial function. However, good function persisted despite tapering of steroids. If this cardiomyopathy is indeed a uraemic complication of uniform origin and evolution its reversal with transplantation suggests a toxic aetiology. Although serial multiplanar echocardiographic studies of our patient's cardiac dimensions and myocardial function were not performed, such studies might be a non-invasive method of determining the prevalence and evolution of this "uraemic cardiomyopathy."

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¹ Bailey, G L, et al, *Transactions. American Society for Artificial Internal Organs*, 1967, **13**, 263.

Wire as suture material

SIR,—I was very interested in your leading article on burst abdomen (26 February, p 534), my particular interest being in the statement that "wire is not the easiest of sutures to use." This statement I would strongly contest. I have used wire as interrupted suture material in this hospital for 23 years with every registrar under my supervision following suit and I do not think there is the slightest difficulty in tying wire sutures. A running wire suture is another matter, but I presume that this is not what is meant in the article. It is also much easier to tie than monofilament polyethylene and in contrast to this material, which occasionally causes a sinus, wire *never* does, I should be interested to have your further comments.

A J M MATHIESON

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* * *What is important is to use a monofilament non-absorbable suture and we are sure that interrupted wire sutures are the equal of interrupted polyethylene. On the other hand, as Mr Mathieson says, although continuous wire is a very good suture material, it is not the easiest of sutures to use.—Ed, *BMJ*.

Need for maintenance diuretic treatment

SIR,—We read with great interest the article by Dr Sylvia M Dobbs and others (19 March, p 749) reporting a controlled trial in which maintenance digoxin was stopped in a group of outpatients. They comment that "a study evaluating long-term diuretic treatment in a similar group of patients would seem to be indicated."

It so happens that we have just published the results of a controlled trial of withdrawing long-term diuretics in 106 elderly people.¹ Our patients differed from those of Dr Dobbs and her colleagues in that they were geriatric inpatients and did not all have a history of cardiac failure. The chief effect of discontinuing diuretics was a tendency for ankle oedema to increase in some patients, but this was usually