the embryonic circulatory system has developed interchange of transplantation antigens is possible; before this some traffic of trophoblastic cells or of subcellular material from the fetal complex to the mother may occur, while the passage of immunopotent substances into the embryo from the maternal circulation is also a possibility. Antigen thus transferred could be not only non-sensitising in form and amount but also capable of defunctioning rejection mechanisms in ways previously reviewed¹ and artificially explored.⁶

Whichever of these hypothetical mechanisms may be shared with the cancer-host and the surgical transplant-recipient systems, it seems clear that the immunological equilibrium existing throughout pregnancy is a dynamic multifactorial system with a steady interchange of immune information and a concomitant ever-changing series of reactions. Knowledge of the kinetics of humoral and cellular responses to the two-way traffic in transplantation antigens is the central need of further understanding.

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¹ Anderson, J. M., *Nature's Transplant*. London, Butterworths, 1972.

² Anderson, J. M., *Proceedings of the Royal Society B*, 1970, **176**, 115.

³ Oldstone, M. B. A., et al., *Nature*, 1977, **269**, 333.

⁴ Anderson, J. M., Stimson, W. H., and Kelly, F., *British Journal of Surgery*, 1976, **63**, 819.

⁵ Stimson, W. H., *Journal of Reproduction and Fertility*, 1975, **43**, 579.

⁶ Anderson, J. M., in *The Biology and Surgery of Tissue Transplantation*, ed J. M. Anderson, p. 129. Oxford, Blackwell, 1970.

Confusion about New Zealand abortion

SIR,—Professor H. C. McLaren (24 June, p. 1697) criticises Dr Richard Smith for his article about abortion in New Zealand (10 June, p. 1533) and suggests that "he offers no support" for his opinion that "most doctors were against the [new] law" and proceeds to throw doubt on the survey he quoted. He follows this with his own opinion about New Zealand abortion politics, which from my three-year experience of working there is pure fantasy (and tells us more about Professor McLaren than about the majority of people in New Zealand).

Dr Smith's article is amply supported by the evidence gathered in two surveys conducted in November 1977 before the new law was passed.¹ Professor R. McD. Chapman, of Auckland University, surveyed all the 4200 doctors currently registered in New Zealand with New Zealand addresses; 51% replied and only 20% of these supported the Bill, which was ultimately passed. The General Practitioner Society conducted a similar survey among 1400 general practitioners; 72.9% replied, and 79% of these doctors, who cannot escape from the problem of unwanted pregnancy in the way that hospital doctors can, agreed with the statement that "a new abortion law should be so formulated as to leave the question of termination during the first three months of pregnancy to the woman and her medical advisers and that the fetus should be afforded the protection of the law in the last six months of pregnancy." Public opinion polls have consistently shown a majority of people in favour of liberalising the law, and the latest of these, in October 1977, given to a random sample of 1000, showed 88% in favour of a more liberal law

than existed then, which was less restrictive than the law which was subsequently enacted. In 1974, with the help of the National Organisation of Women (Gisborne branch) I conducted a survey of opinion about abortion among the 62 doctors practising in the east coast area. Apart from the two doctors who tore the form up (who probably would see things in the same way as Professor McLaren), replies were obtained from 57. Just over 50% agreed with the statement that "abortion should be a personal decision between the woman and her physician" and subsequent referral practice confirmed the validity of these responses.²

In the three years I worked in Gisborne the need for termination was apparent and attitudes were very similar to those in England. The effect of the restricted abortion law now passed will be to prevent the older, more parous, poor woman from obtaining an abortion as the younger, nulliparous woman with no responsibilities and the rich will fly to Australia, where large series have already been reported.³

Professor McLaren may have been influenced by the attitudes of some members of the Royal New Zealand College of Obstetricians and Gynaecologists, some 50% of whom, when surveyed for the Royal Commission on Sterilisation in 1975, disapproved of abortion on either ethical or "other" grounds⁴; but I doubt that even Mr Muldoon's supporters would say that "tolerance and compassion" were his strong points and the passage of the new Act through the New Zealand Parliament was considered by many observers to be an abuse of the democratic system.

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¹ Facer, W., *New Zealand Nursing Forum*, 1978, **6**, 13.

² Savage, W., *Proceedings of Royal Commission on Contraception, Sterilisation, and Abortion*. Wellington, Government Printer, 1976.

³ Rogers, A. F. C., and Lenthall, J. F., *New Zealand Medical Journal*, 1975, **81**, 282.

⁴ Royal New Zealand College of Obstetricians and Gynaecologists, *Proceedings of Royal Commission on Contraception, Sterilisation, and Abortion*. Wellington, Government Printer, 1976.

Phenistix urine test-strip and desferrioxamine

SIR,—Twins aged 16 months were admitted to our unit on 21 April 1978 having ingested an unknown number of ferrous gluconate 300 mg tablets about 25 min before admission. Immediate treatment was instituted, including the administration of desferrioxamine mesylate. Samples of venous blood taken 3 h 50 min after the iron ingestion gave serum iron readings of 51.5 $\mu\text{mol/l}$ (288 $\mu\text{g}/100\text{ ml}$) and 56 $\mu\text{mol/l}$ (313 $\mu\text{g}/100\text{ ml}$) respectively.

Specimens of urine from all children admitted to this hospital have for several years been tested with a Phenistix strip, partly as a screening procedure for unsuspected salicylate poisoning. When a Phenistix test was carried out on a urine specimen obtained from each twin after the desferrioxamine had been administered a very deep red-brown colour resulted. A repeat venous blood sample from each of the twins at 23 h after the iron ingestion showed no demonstrable salicylate content, while the serum iron readings were 12.5 $\mu\text{mol/l}$ (70 $\mu\text{g}/100\text{ ml}$) and 10.5 $\mu\text{mol/l}$ (59 $\mu\text{g}/100\text{ ml}$) respectively. The urinary Phenistix test was

entirely negative in both children 25 h 30 min after the iron ingestion.

Two urine specimens from a patient with thalassaemia, one taken before and the other after the administration of desferrioxamine, have been tested with Phenistix, and the same change was seen in the second specimen. Desferrioxamine mesylate solution taken from an ampoule and then well diluted will produce a similarly striking change when applied to a Phenistix strip.

Although the urine of patients receiving desferrioxamine can have a characteristic reddish discoloration, the Phenistix test-strip is at manufacture impregnated with ferric ammonium sulphate along with other substances.

I wish to thank student nurse Sonia C. Archibald, who drew attention to the abnormal Phenistix reaction in the twins.

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Platelet MAO activity in epilepsy

SIR,—Your leading article on serotonin, platelets, and autism (24 June, p. 1651) was of considerable interest to us because we have been studying the platelet monoamine oxidase (MAO) activity in patients with epilepsy, a disorder which may accompany infantile autism and mental illness. Our results from earlier investigations showed that tyramine, a substrate for MAO, activated the electroencephalogram of epileptic patients,¹ and preliminary analysis of our present results shows that the platelet MAO activity is significantly raised in epileptic patients when compared with neurological controls and normals. There are also some sex differences. All the epileptic patients were taking anti-convulsant medication, and it may be that this is important.

It is possible that our observations relate directly to a biochemical substrate for epilepsy at a cellular level, and it is hoped to publish full results shortly.

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¹ Swash, M., Moffat, A., and Scott, D. F., *Nature*, 1975, **258**, 749.

Management of intracranial metastases

SIR,—We noted with regret that the article by Mr M. M. Sharr and Mr J. S. Garfield (10 June, p. 1535) failed to mention the place of palliative radiotherapy in the management of patients with intracranial metastases.

The neurosurgeon deals with a small and highly selected group of these patients. They are often those presenting with undiagnosed cerebral metastases or with a solitary intracranial deposit. Even in this group of patients the results of surgical intervention either with or without postoperative radiotherapy are acknowledged to be poor.^{1,2} The operative mortality alone in some series is as high as 20%.²

By contrast the value of radiotherapy alone in the management of patients with multiple