May I, through your columns, suggest that confused patients should not be allowed to leave a mental hospital except to the care of a competent relative or friend? The present "open doors" policy in mental hospitals is being carried too far, and results in some of these unfortunate patients being exposed to unnecessary danger, as well as causing additional work for the police, mental welfare officers, and police surgeons.—I am, etc.,

H. D. LEGGATT.

Abortion and the Psychiatrist

SIR,—The subject matter of the article by Dr. Myre Sim entitled "Abortion and the Psychiatrist" (July 20, p. 145) is of the greatest importance to all medical practitioners. Unfortunately, in common with the authors he quotes, Dr. Sim is unfamiliar with the law concerning medical termination of pregnancy.

Davidson's *Medical Ethics*, published in 1957,¹ has a chapter on abortion written by Roques. After quoting from the Act of 1861 he states: "It must be clearly understood that there are no exceptions to the rule: it necessarily follows that every time abortion is induced, for whatever reason, a felonious act of considerable magnitude is perpetrated. Nevertheless, in cases in which pregnancy is terminated for medical indications in good faith by reputable practitioners the police never take proceedings." This statement is quite wrong, because there is an exception to the statute which is well established as part of the law.

The interpretation first adopted in the Bourne case has been reaffirmed on two occasions. In *Rex v. Bergmann and Ferguson* (1948) the judge ruled that the question to be considered was not whether the operation was in fact necessary but whether the surgeon honestly believed it to be necessary; if so the operation was justified. In *Rex v. Newton and Stungo* (1958) the trial judge took the further step of ruling that termination of pregnancy was lawful to preserve the mother's life or health; and he expressly included not only physical but mental health. The Bourne ruling is now part of the law of England, and if for some reason a trial judge refused to follow it he would be reversed on appeal.

Dr. Sim quotes Ekblad² as having found 11% of his series of patients with "undesirable sequelae of a psychiatric nature" after termination of pregnancy. On reading Ekblad's paper one finds the following statement: "Detailed case histories are given for 54 women (11%) who had felt serious self-reproaches or who had regretted the operation. A closer study of the case histories of these women with serious self-reproaches shows that even if their subjective sufferings due to the abortion were severe, from the psychiatric point of view their depression must in general be

designated as mild. It is only rarely that the women's working capacity has been impaired or that they have needed to consult a doctor on account of their mental troubles." Ekblad does not "conclude"—"The psychiatrically abnormal find it more difficult than the psychiatrically normal to stand the stress implied in a legal abortion. This means that the greater the psychiatric indications for a legal abortion are, the greater will be the risk of unfavourable psychic sequelae after the operation." These are the first two sentences of the summary of a quite different chapter in the monograph. At the International Planned Parenthood Federation conference in Stockholm (1953) Ekblad said: "In my opinion the study shows that we need not be afraid of performing a legal abortion for fear of severe psychic harm to the woman."

According to Dr. Sim, Siegfried³ found 59% of guilt reactions in his series of therapeutic abortions. What, in fact, Siegfried reported was the psychiatric follow-up of 61 women who had had legal abortions, and, of these, 51 were simultaneously sterilized. He found that the commonest reaction to the abortion was that it left behind an unpleasant memory which was sometimes combined with remorse and feelings of guilt. When they were overtaken with any misfortune—for example, when one of the children became ill—then they often thought of the abortion and asked themselves whether they were now expiating the abortion through the child's illness. In spite of such thoughts these women were glad of the abortion, to which they did not ascribe such great importance that it disturbed their peace of mind. This way of reacting to the legal abortion, which was found in 59%, was considered by Siegfried to be the most normal and the most easily understood. A smaller number, 28% in this material, showed no psychic reaction to the abortion at all. They were only glad for the operation and thought no more about it afterwards. Eight women showed unfavourable sequelae after the operation, but it was thought that six of these would have been as badly, or worse, off had they completed their pregnancies.

Dr. Sim quotes Dahlgren⁴ as having found only 3.7% of the women pregnant in a study of attempted suicide. Dahlgren's paper concerns 95 women between the ages of 15 and 44 years who were admitted to hospital because of attempted suicide. Five of them were pregnant and all five were unmarried. The "remarkable negative finding" that no unmarried mothers are to be found in Dr. Sim's series suggests to me that his material has been highly selected. What I find really remarkable is the conclusion "Unmarried mothers are relatively immune from puerperal psychosis."—I am, etc.,

London S.W.11.

PETER DARBY.

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Psychiatry and Appendicitis

SIR.—Dr. H. E. Harding¹ suggested that psychogenesis might be important in patients whose appendices were histologically normal following operation for acute appendicitis. He noted a percentage of 39.6 normality out of 1,320 specimens, rising to nearly two-thirds in the age group 11 years to 20 years.

I examined 25 unselected consecutive patients operated upon for acute appendicitis (16 males, 9 females) whose age distribution was comparable to that of Dr. Harding's sample. The patients were rated (0–5) for neurotic reaction following a standard psychiatric interview in the immediate post-operative period, and each patient completed a Cornell Medical Index Health questionnaire (C.M.I.)² to afford some external validation of the clinical evaluation. Histological reports were obtained after the psychiatric evaluation was completed. Comparison of the rating scale and C.M.I. score (20 or above for severe neurotic reaction) was highly significant ($P < 0.01$) using χ^2 technique for small numbers. No significant relationship was noted comparing either clinical rating or C.M.I. with histological abnormality (Tables I and II).

TABLE I

Nos.	Psych. Rating	Histology	
		Abnorm.	Norm.
12	0, 1, 2, 3	9	3
13	4, 5	8	5
Totals : 25	—	17	8

TABLE II

Nos.	C.M.I. Scale	Histology	
		Abnorm.	Norm.
15	Under 20	11	4
10	20 or above	6	4
Totals : 25	—	17	8

The problem of assessing "stress," either chronic or acute, and its clinical relevance presents many problems. Though a wide variety was revealed, relating to domestic and interpersonal areas, work, and finance, etc., the relationship to acute appendicitis was not evident.

The following points summarize the above:

1. No significant relationship was found between neurotic reaction and histological evidence of acute appendicitis—the incidence and histology of appendicitis in a psychiatric population might be of interest.

2. The clinical relevance of histological data such as "oedema," "fibrosis only," "lymphoid hyperplasia" is obscure and in the absence of acute inflammatory

change such appendices were classified as normal in the present study.

3. The more detailed study of children and adolescents³ might still be worthy of further study, if clinicopathological correlations can be defined.—I am, etc.,

Beckenham, Kent. M. D. EILENBERG.

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- ¹ Harding, H. E., *Brit. med. J.*, 1962, 2, 1028.
- ² Brodman, K., Erdmann, A. J., Lorge, I., Gershenson, C. P., and Wolff, H. G., *J. clin. Psychol.*, 1952, 8, 289.
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Registration Fees

SIR,—The General Medical Council has recently (June 1, p. 254) amended its Standing Orders relating to fees. These fees are demanded for entry in the *Medical Register* of additional qualifications, recognized diplomas, changes of name, and the like. Since it is the statutory duty of the Registrar "to keep the Register correct and to make any necessary alterations in the addresses or qualifications of registered persons," is it not curious that his readiness to do this duty should be conditional upon the receipt of a fee?

Some time ago the Registrar somehow became aware that I possessed additional qualifications. He sent me a circular letter enclosing a form of application to have them registered and drawing attention to the schedule of fees. I was sorry to see the *Register* incorrect, but whoever would dream of paying a fee in this year of grace to have a public officer get cracking on his statutory duty? So far as I know the *Register* is still incorrect. In fact, I gather that it is riddled with obsolete information and that the standard work of reference is an unofficial publication, having a large sale that recoups the cost of keeping it accurate year by year.—I am, etc.,

Sydney, Australia. DOUGLAS ANDERSON.

Echo Encephalography

SIR,—The recent publication of the admirable work of Robert Ford and James Ambrose¹ perpetuates a widespread false impression as to the originator of this valuable new technique.

The originator was probably D. H. Howry, of Denver, Colorado, but he did not publish work on the echoes he obtained from the brain until later.

The first public demonstration of the technique was, as far as I have discovered, at the Physical Society Exhibition in Imperial College, London, in the spring of 1954 when Turner and Smith of the Royal Cancer Hospital (now Royal Marsden Hospital) department of physics demonstrated that it was possible to obtain echoes from the mid-line structures from the temporal areas and to obtain some indication of the ventricular size from temporal and frontal areas. They also reported the detection of echoes that altered in time with the carotid pulse.

Impressed with the possibilities of this technique I obtained the loan of a flaw-detector from Kelvin & Hughes Ltd. (now Smiths Industrial Division) and read a paper to the Fourth Symposium Neuroradiologicum on September 13, 1955, describing the technique and forecasting its likely development. This paper, though handed in to the Symposium organizers, was reported by title only in the proceedings.²

Leksell did not publish until 1956³ though he began work in this field in the same year as the Marsden workers—that is, 1953. It is to be hoped that the second decade will show a much more rapid extension of the technique which even now at the West End Hospital for Neurology and Neurosurgery, where it was introduced, has to depend on an eight-year-old apparatus privately owned.—I am, etc.,

Richmond, Surrey. DOUGLAS GORDON.

REFERENCES

- ¹ Ford, R., and Ambrose, J., *Brain*, 1963, 86, 189.
- ² Gordon, D., *Acta radiol.*, 1956, 46, 4.
- ³ Leksell, L., *Acta chir. scand.*, 1956, 110, 301.

Prevention of Rheumatic Fever

SIR,—Your reply to Dr. Patrick Wood's letter (July 13, p. 115) must, I hope, have been written in haste. Surely at this stage in the use of antibiotics "indiscriminate antibiotic therapy" is to be deprecated as bad medicine, but we find you recommending the prescription of "30 tablets of penicillin" over ten days. It would be helpful if you were to be more precise and were to mention the type of penicillin that is effective when given as one tablet three times a day.

Surely we have learnt that the prescribing of a partially efficient antibiotic over a period of ten days is the cause of much unnecessary illness. According to Dr. Wood's figures 2,000 children are put at risk so as to attempt to prevent three cases of rheumatic fever.—I am, etc.,

Petworth, Sussex. W. ANTONY BALL.

Morphine in Diverticulitis

SIR,—Mr. N. S. Painter and Dr. S. C. Truelove (July 6, p. 33) publish some interesting observations on the action of morphine on the colon affected by diverticulosis. While one must agree that it is undesirable to use a drug which increases activity in the presence of inflammation, I believe there is some exaggeration in suggesting that an increase of intracolonic pressure will cause distension and possibly rupture of diverticula which are affected by chronic disease. The term "diverticulitis," as applied so frequently to the commonly seen picture of left ilio-fossa peritonitis, is a misnomer. A true diverticulitis is rare, and the common lesion is a diffuse segmental peridiverticulitis or pericolicitis. If diverticula are recognizable in the segment involved they are obliterated by previous inflammation and certainly incapable of distension.

Perforation of a diverticulum, recognizable as such, is also relatively rare, and if general peritonitis arises from acute disease it follows seepage or perforation of one or more intramural abscesses which form in an area of cellulitis of the wall of the colon. Even if a faecal leak occurs this is more often after rupture of an abscess than from free perforation of a diverticulum behaving like a perforated appendix.

All surgeons recognize the serious consequences of acute perforative lesions which are a sequel of diverticular disease. A failure to appreciate the true pathology of these conditions may account for misunderstanding and even mismanagement. I have discussed these problems more fully elsewhere,¹ but would like to emphasize once more the confused application of the term "diverticulitis."

In the conservative treatment of an inflammation which is usually self-limiting relief of pain by the judicious use of morphine or pethidine is necessary. Although there is a case for the use of pethidine in that it induces less colon activity than morphine, I do not think that clinical experience suggests that morphine has in the past increased the risk of perforation. Nor do these cine-radiographic studies imply that morphine can increase this risk with a lesion that is usually diffuse.—I am, etc.,

Gayton, Cheshire. JOHN A. SHEPHERD.

REFERENCE

- ¹ Shepherd, J. A., *Surgery of the Acute Abdomen*, 1960, chapter 12, pp. 631-651. E. & S. Livingstone, Edinburgh.

Meprobamate

SIR,—It was recently stated in the "Today's Drugs" series (July 20, p. 163) that agranulocytosis has been reported with meprobamate. As the only two words given any prominence in the relevant paragraph were meprobamate and agranulocytosis, the reader may have been left with the impression that this was a common toxic effect of the drug.

I understand that the statement was, in fact, based on a single report of a patient who was found to have aplastic anaemia some weeks after being treated with meprobamate for eight days.¹ In the six years since that case was reported, meprobamate has been administered literally in tons of drug without a single similar case being reported where a definite cause-and-effect relationship has been suggested. The fact that doctors are not slow to publish such toxic reactions, should they occur, is illustrated by reports of blood dyscrasias with combinations and where a coincidental relationship was suggested.²⁻⁷

There is a tendency at the present time to give wide publicity to isolated toxic reactions, and, while this is valuable as a warning to look for similar effects, it is necessary to keep a sense of perspective.

As far as meprobamate is concerned, the warning given six years ago has produced no similar reports in the inter-