this country to procure an abortion before quickening had taken place. It is this permissive legislation which Glanville Williams and many others advocate. Until recently many medical men were opposed to abortion-law reform because they were convinced that the operation was dangerous and that there were considerable psychological sequelae. It was also surmised that legal abortion increased the number of criminal abortions. So many papers from abroad have been published refuting these beliefs with hard, cold facts that opponents of reform are now obliged to resort to other arguments.

Nobody in possession of the facts thinks of abortion as a "cure" or as the ideal solution to marital or population problems. Abortion is simply the lesser of two evils in so many cases, and a legal abortion is infinitely preferable to the criminal variety.—I am, etc.,

London S.W.11.

PETER DARBY.

REFERENCE

¹ *Midwifery*, edited by F. W. Roques *et al.*, 1961, 10th ed. Arnold, London.

SIR,—May I be allowed to comment on your leader on abortion law (17 April, p. 1009)? This is an extremely complicated problem. It involves not only an operative procedure in itself, but because the primary purpose of medical practice is to save life rather than destroy it it involves the moral and professional feelings of both the gynaecologist and the theatre staff who have to assist at the operation. In addition it involves complicated ethical, religious, and social concepts both for the patient and society as a whole.

Illegal abortion is carried out on a large scale. For those who can pay it is carried out elegantly with little or no risk to the woman involved; for those of meagre means the consequences of back-street abortions are serious in terms of human health and life.

I sympathize with your solution that the proper way to put out of business the back-street abortionist is through cheap and reliable contraception. However, this is, unfortunately, not only a counsel of perfection but an ineffective solution. The facts are that there is no absolutely reliable form of contraception except perhaps the pill, which unfortunately is not tolerated by an increasing number of women, and as yet there is no proof that it is free from undesirable long-term effects. In my experience an increasing number of women have a deep emotional resistance to the pill. Furthermore, one sees frequent cases of unwanted pregnancy due to a failure of mechanical means of contraception. In addition there are deep as well as superficial emotional reasons why many people who wish to avoid pregnancy do not in fact use contraception—for example, all forms of contraception interfere in some way or another with the full enjoyment of the sexual relationship. It is true that this interference is often psychological rather than physiological, nevertheless it is clear that contraception in itself does not and probably never will eliminate an unwanted pregnancy.

In my own experience I have seen many women whose lives would be under an intolerable emotional strain if they were to go on with an unwanted pregnancy. It is true that termination on psychiatric grounds can rarely be justified because of a risk of serious mental

breakdown, but if we are concerned with positive mental health not only of the pregnant woman but also of her whole family, particularly her other children, then we must take a much broader view of this problem.

There is something to be said for the view that a woman has the right to decide for herself whether she should continue with her pregnancy; it is she who has to bear the child and it is she who has to rear it. We have enough knowledge about the development of personality to know that if a woman deeply resents the birth of an unwanted child or is psychologically incapable of mothering satisfactorily too many children then the consequences in terms of mental health for that child and the rest of her family are grave. She may be laying the foundation of psychiatric illness in the next generation. I would therefore suggest that the medical profession should give serious thought to the proposals of Mr. Glanville Williams.

In my view termination of pregnancy should be a private matter between the woman and her medical advisers and that of her husband. Careful consideration should be given to all the factors operating in the case, and where social-psychological reasons are pre-eminent the decision should be taken after careful assessment and consultation between general practitioner, obstetrician, and psychiatrist. I would therefore take issue with your statement that such a Bill by Glanville Williams would not have the assent of the medical profession. Such a statement indicates a too conservative, restrictive, and simple approach to the problem.—I am, etc.,

The Towers Hospital,
Humberstone, Leics.

H. B. KIDD.

M.P.U. and G.P.A.

SIR—I was very surprised to find in your correspondence columns (24 April, p. 1129) publication of a letter which I had received from Dr. Gerald Biss of the G.P.A., to which at that time I had not had an opportunity to reply. I had not been informed of his intention to publish his letter to me, and as the matter was concerned with comments made by me in the *Medical World Newsletter* I consider that it would have been more courteous of him had he asked for his reply to be published in that journal.

With regard to the substance of my comments in the *Medical World Newsletter* that repeated approaches to the General Practitioners' Association had been unsuccessful, I pointed out in my reply to Dr. Biss that in addition to the "formal" approach in January to which he referred unofficial approaches had been made subsequently on at least two further occasions with equally unrewarding results. The indignation expressed in Dr. Biss's letter is made to appear somewhat synthetic by his final paragraph, which clearly states that the G.P.A. has set out to remain in isolation from other medical organizations, thereby completely substantiating my argument.

I find this attitude very disappointing, as in the present state of affairs in the National Health Service it is essential that all those who are concerned for its future welfare should work in the closest co-operation.—I am, etc.,

P. SIDNEY GREAVES,
General Secretary,
Medical Practitioners' Union.

Prefrontal Leucotomy

SIR,—It is to be hoped that your leading article on prefrontal leucotomy (24 April, p. 1083) will not "reinforce opinion against an operation which is already in decline" to such an extent that this method of treatment is withheld from the small group of psychiatric patients who can benefit greatly from it—i.e., those severely handicapped by chronic tension and anxiety, and some severe obsessional. The disability from which these patients suffer is almost certainly genetically determined and is not amenable to psychotherapy; drug therapy, whilst giving some benefit, once started has to be continued indefinitely, often with diminishing effectiveness. The risks of leucotomy in these patients have to be weighed against (1) the risk of suicide (considerably higher I should think than the mortality from leucotomy, which is very small indeed), and (2) the risks of *really long-term* administration of drugs, which are in the case of many modern drugs used in psychiatry quite unknown.

The findings of the Canadian workers quoted in your article that the operation was not significantly successful in a series of patients suffering from functional psychoses will not come as any great surprise to psychiatrists here, since the vast majority would not now recommend the operation for these disorders.—I am, etc.,

Department of Psychiatry, W. J. STANLEY.
General Hospital,
Ashton-under-Lyne, Lancs.

Diabetes Mellitus and Cyclophosphamide

SIR,—I would like to record the development of diabetes mellitus in patients treated with cyclophosphamide. I have seen this now three times, which appears to be an unlikely coincidence. Brief case histories are as follows:

Case 1.—Female, aged 63 years. Carcinoma of the right breast with carcinomatosis. She presented with jaundice in April 1962. An inoperable primary carcinoma of the left breast was present. Treatment with cyclophosphamide was started on 24 April 1962, 200 mg. daily. On 14 May 1962 the dosage was reduced to 150 mg. daily and continued until November 1963, when the white count had fallen to 1,500/c.mm. Glycosuria was first observed on 18 December 1962. A blood sugar on 11 December 1962 was 195 mg./100 ml. and on 22 January 1963 was 255 mg., and thereafter control was achieved with chlorpropamide 250 mg. daily and a low-carbohydrate diet. She died on 27 June 1964, having come into hospital with a blood sugar of 320 mg./100 ml. and severe ketosis. At necropsy the histology of the pancreas was badly preserved, and it was impossible absolutely to exclude the presence of metastases in the pancreas. Some islets were present and there was some interlobular pancreatic fibrosis. Multiple liver secondaries were present.

Case 2.—Female aged 64 years. Carcinoma of breast with bony secondaries. A left radical mastectomy was performed on 5 June 1963, following which there was good healing. There was no evidence of secondary deposits. She started complaining of pain in the back and lower abdomen in January 1964, when she was found to have metastases in the ribs, spine, and pelvis on x-ray. Cyclophosphamide 150 mg. daily was started on 15 January 1964. Glycosuria was first observed on 26 June 1964, when she was complaining of increased thirst and polyuria. The fasting blood sugar was 220 mg./100 ml. Control of the diabetes was achieved with tolbutamide 1 g. twice daily and a low carbohydrate diet. Following this, she developed

multiple cutaneous metastases. Meningitis followed a hypophysectomy on 11 February 1965 and she died soon afterwards. At necropsy the pancreas showed islet tissue present in normal amounts, and there was no abnormality in the histology.

Case 3.—Female aged 62 years. Carcinoma of left lung with pleural effusion. She was treated with cyclophosphamide 100 mg. daily from 15 June 1964 to 11 September 1964, thereafter 50 mg. daily. Glycosuria was first observed on 12 December 1964 and a glucose-tolerance test on 8 March 1965 showed fasting level 100 mg./100 ml.; after 50 g. of glucose: at $\frac{1}{2}$ hour 220 mg./100 ml.; at 1 hour 210 mg./100 ml.; at 1½ hours 230 mg./100 ml.; and at 2 hours 210 mg./100 ml. Control of the blood-sugar level has been achieved with a low-carbohydrate diet.

There was no family history of diabetes in any of these patients.

—I am, etc.,

Altrincham, Cheshire.

C. R. PENGELLY.

Portal Venography

SIR,—In your leading article on portal venography (17 April, p. 1013) you do not do justice to portal venography by direct injection of contrast medium into an accessible radicle of the portal vein. Those of us who consider that the indications for operation in portal hypertension are clinical reserve radiological demonstration of the portal venous tree until the time of the operation itself, thereby saving the patient the stress and undoubted anxiety of splenic venography under local anaesthesia and obviating the risks of that procedure, which, as you mention, may not demonstrate the portal vein if there is much diversion of portal blood along the collateral channels. Streamlining of portal blood may lead to further errors in interpretation by mimicking the appearances of mural thrombosis, and it is for this reason that the opportunity of supplementing a splenic injection by a jejunal vein injection much closer to the portal vein has obvious advantages. Seldom does any difficulty arise in deciding that portal vein thrombosis is present.

The complementary method of direct injection is therefore often necessary. It is simple, quick, and safe. We have always found it possible to obtain a suitable vein for injection. It has not failed us on over 500 occasions, mostly in operations for portal hypertension. It is the most certain way of demonstrating the portal vein itself and the radicles entering it, which is the information the surgeon wants. We have never found that it "produces a distorted picture of the portal venous system," nor is it necessary to inject large quantities of contrast medium. The correct timing of the exposures after quick injection of no more than 20 ml. gives excellent definition.—We are, etc.,

ALAN H. HUNT.

ROBERT KEMP HARPER.

St. Bartholomew's Hospital,
London E.C.1.

Foster Parentship

SIR,—Following the letter of 24 April, p. 1128, it seems to me important that there should be correspondence in the *British Medical Journal* on the problems of foster-children, but that we should not set a fashion against fostering even though we know that the most

unhappy children are those who have failed in a foster-home.

Mr. A. B. Alexander makes the point that the fundamental difference between adoption and fostering is that the latter is a salaried service, whereas I would consider the fundamental difference is in the quality of "belonging" that a child feels when successfully adopted in its adoptive home. On the other hand, if adoption fails in adolescence it is helping the adolescents accept their feelings of "unbelonging," with no hope of re-finding the real parent because of the legal difficulties entailed, that at times makes the rehabilitation of the failed adoption far more difficult than the failed fostering.

Far from foster-parents' receiving a salary being detrimental to good fostering, there are many workers with these children who know how expensive these children's destructiveness can be, and we feel that the foster-parent is inadequately remunerated for the work which needs to be done.

I have about 50 local authority children whom I have known for over five years, who telephone, write, or come and stay with me when they feel that I can help them. Some of them are in children's homes, others in foster-homes. Most of them, in spite of adverse early histories, are making good. It would seem to me the fundamental need of these children is that they should be consulted, and be given the choice as to where they wish to live, and that every effort should be made when we know that a child has formed a relationship with an adult of his choice to keep them together, or at least for them to have holidays together.

I am sure that family doctors, by referring foster-children to child guidance clinics, could reduce the number of foster-home breakdowns.—I am, etc.,

JOSEPHINE M. LOMAX-SIMPSON.

South London Hospital for
Women,
London S.W.4.

Breathing Exercises in Asthma

SIR,—In the article by Dr. A. P. Norman on asthma in the Child Care in General Practice series (1 May, p. 1171) I note that no mention was made of the place breathing exercises play in the treatment of this condition. My own view is that it works in two ways, cutting down the need for drugs and thus making them more effective and inculcating a more physiological type of breathing. This may well cut down the residual bronchitis in middle age where the asthma clears up in early adult life.

I was pleased to note that your author, Dr. A. P. Norman, places the emotional aspect in the right context.—I am, etc.,

LEWIS B. PETERS.

County Borough of Brighton
School Health Service,
Brighton 7, Sussex.

"Unprepared" Pyelograms

SIR,—In Singapore we see a lot of renal colic in the Services population and would confirm the value of an "emergency I.V.P." in the diagnosis of this condition, as suggested by Mr. J. M. Foreman (30 January, p. 318).

We, too, have found that unless the colic was due to an obvious impacted opaque stone

a booked I.V.P. would be in most cases virtually useless, even after as short a time as two days after the attack. Only a little doubtful fullness might be seen on the affected side. Now we try to get the I.V.P. done while the patient still has some colic.

It is in fact easier, with a 24-hour radiographic service, to do the I.V.P. as the patient appears. Plain films of abdomen and bladder area, 40 ml. of 45% Hypaque intravenously, and films to show the whole length of the urinary tract at 15 minutes and 30 minutes after the injection, followed by an after-micturition film, offer no greater problem to a duty medical officer and a single-handed duty radiographer than the average accident or theatre case.

Normal appearances in the presence of continuing pain make a diagnosis of renal colic untenable, while non-function, nephrographic effect or hydronephrosis with or without hydroureter prove the presence of obstruction. In the case of the latter two the exact site of obstruction can be shown by further films if necessary. Our cases of renal colic can now, in the main, be accurately diagnosed within 24 hours. We hope to submit some results for publication in due course.

The procedure is described by Saxton and Strickland.¹ Smith has given an account of 40 I.V.P.s performed during renal colic, and quotes Wulff² as having demonstrated the value of the procedure nearly 30 years ago in Sweden.—We are, etc.,

P. M. BRETLAND.

I. M. CRAN.

British Military Hospital,
Singapore.

REFERENCES

- ¹ Saxton, H. M., and Strickland, B., in *Practical Procedures in Diagnostic Radiology*, 1964, p. 39. H. K. Lewis, London.
- ² Smith, I., *Proc. roy. Soc. Med.*, 1964, 57, 573.
- ³ Wulff, H. B., *Acta radiol. (Stockh.)*, 1936, Suppl. 32.

Neurological Complications of Glandular Fever

SIR,—The patient reported by Dr. S. K. Mukherjee (24 April, p. 1112) is of great interest, but the interpretation of the clinical features described is perhaps unduly dogmatic.

The history of pain followed by severe motor weakness, the subsequent disappearance of the pain but persistence of weakness and atrophy of shoulder girdle muscles are strongly suggestive of "neuralgic amyotrophy."^{1,2} Although a small area of sensory impairment is common, it is by no means an invariable finding in this condition.

The pathology of neuralgic amyotrophy is uncertain, since no necropsy material has been studied in this non-fatal disease. However, it seems highly probable that this disorder, serum neuritis, and the experimental allergic neuritis of Waksman and Adams,³ all have a similar pathological basis⁴ consisting of inflammatory and degenerative lesions which are maximal in the dorsal root ganglia and nerve roots. There is certainly no pathological evidence that the anterior horn cells of the spinal cord are involved in these patients,⁴ with the exception of those cases exhibiting the more grave clinical and pathological features of post-infective "encephalomyeloradiculitis."

Although of uncommon occurrence, lesions of nerve roots, isolated peripheral nerves, and