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CORRESPONDENCE

Correspondents are asked to be brief

Induction of Therapeutic Abortion with Urea

SIR,—With reference to the article by Mr. J. D. Greenhalf and Mr. P. L. C. Diggory (2 January, p. 28) since March 1970 we have terminated 61 mid-trimester pregnancies where therapeutic abortion was required, using a hypertonic urea solution. Eighty grammes of urea, dissolved in 210 ml 5% dextrose (Ureaphil), was given by abdominal amniocentesis, the patients being given basal sedation with Valium (diazepam) 10 mg and Fortral (pentazocine) 30 mg intravenously and local anaesthetic to the skin. After urea instillation the blood urea was measured at planned intervals for 24 hours to assess the rate of excretion.

In our experience, the induction-abortion delivery interval was so long that stimulation of labour with intravenous Syntocinon (synthetic oxytocin) was necessary. A high dose of Syntocinon was effective (50 u/l. of dextrose saline) and the infusion was given over four hours. It was reepated on successive days if necessary.

Analysis of the Induction-abortion Interval in 51 Patients

Induction-abortion Interval	No. of Patients	
>24 hours	3	27
24–48 hours	9	
48–72 hours	15	
4–7 days	19	24
8–14 days	2	
<14 days	3	
Total	51	

At first we were exploring the method. When we experienced the long delay between amniocentesis and abortion in some cases, we decided to give a high-dose Syntocinon infusion after five days. Now our practice is to start this 24 hours after urea instillation, with considerable improvement in results.

Out of our total series of 61 patients 14 required dilatation and curettage; 1 required hysterotomy, when a dead fetus was delivered; 1 had a second urea instillation, with good effect; and 1 (included in this series but operated on at another hospital) developed intrauterine infection; she aborted the fetus in the lavatory and did not report this fact to the nursing staff. The placenta was retained for several hours. The infection responded rapidly to an antibiotic and the placenta delivered spontaneously, but a curettage was performed to ensure complete evacuation of the uterus.

We plan to publish our results in a specialist journal, but have delayed doing so until we had defined a method which took account of and dealt with the problems invoked by this regimen. In our view the routine administration of a high-dose Syntocinon infusion is valuable in ensuring rapid completion of the termination of pregnancy.—We are, etc.,

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Endocrine and Metabolic Disorders in Bronchial Carcinoma

SIR,—We are surprised at the high incidence of hypercalcaemia reported by Dr. J. G. Azzopardi and others (28 November, p. 528). Despite the by now well-established situation of parathormone activity being often related to squamous cell carcinoma,[1] in most cases it is very difficult to distinguish between hypercalcaemia due to bone metastases and that due to the endocrine disorder following excessive secretion of inappropriate parathormone. In our view it is impossible to differentiate between these possibilities using clinical variables alone without determining the level of parathormone activity. Unfortunately, not only is the estimation of parathormone activity difficult, but also bronchial carcinoma frequently metastasises to bone. Tumours which are large and have been growing for some time are frequently associated with clinically undetected bony metastases. Furthermore, there is no correlation between the size of a tumour or a metastasis and its biochemical activity. It is a characteristic feature of endocrine paraneoplastic syndromes that they are associated with small tumours; when these tumours do produce hormones, the rate of production is excessive and is not related to the size of the tumour.

In a series of 300 cases of bronchial carcinoma which one of us (P.v.W.) has seen in Hamburg there have been no definite instances of hypercalcaemia due to paraneoplastic endocrinopathy. According to the literature which has been published to date, the incidence of paraneoplastic hyperparathyroidism is very low (7% of all tumour-related endocrinopathies[2]).—We are, etc.,

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1 Omenn, G. S., and Wilkins, E. W., *Journal of Thoracic and Cardiovascular Surgery*, 1970, **59**, 877.

2 Kracht, J., *Medizinische Klinik*, 1968, **63**, 41.