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Correspondence

Correspondents are asked to be brief.

Abortions under the N.H.S.

SIR,—The Abortion Act (1967) states that "in determining whether the continuance of a pregnancy would involve such risk of injury to health . . . account may be taken of the pregnant woman's actual and reasonably foreseeable environment."

I am frequently faced with two socio-economic problems. Firstly, the married woman with poor living conditions, inadequate for her present family, let alone an additional child. It may be that she and her husband live in one room, sharing a double bed with one or more children, with a cot for the youngest. Ablutions may take place in the kitchen, or in a communal washhouse. Not infrequently the woman goes to work, either because her husband is missing or does not provide sufficient money.

Secondly, a single girl, ignorant or careless about contraception, and frightened to tell her parents of her predicament. The putative father no longer seems to take any responsibility, and she cannot face the consequences of pregnancy, which entail either giving up her job or her training.

It seems to me that social services do remarkably little for either the unmarried girl or the married women with poor housing conditions, even if they could be persuaded to continue with their pregnancy. It is not surprising that they suffer from a reactive depression, and I believe that abortion should be available to them on the National Health Service. It is speedily available in the private sector for those who can afford or can borrow the money. Unfortunately the waiting list for outpatient appointments is increasing, and there may be unavoidable delay in admission to hospital. According to the *Annual Report* of the Chief Medical Officer of Health for 1969[1] the number of patients on gynaecological waiting lists has increased considerably.

The mortality from legal abortion before 12 weeks may be lower than maternal mortality excluding abortion, but the risks of abortion increase after 12 weeks, and altogether in 1969 there were 18 deaths associated with over 54,000 pregnancies terminated.

The increasing number of notified abortions can be controlled only by improved sex education and freely available contraception, but this will take time. There is an urgent need for additional outpatient facilities, and either an increase in beds, preferably separated from other gynaecological patients, or a better use of the existing beds. For this we need an increase in staff, medical, nursing, and medical social workers.—I am, etc.,

H. G. E. ARTHURE.

London, W.1.

REFERENCE

1 Department of Health and Social Security. *On the State of the Public Health: Annual Report of the Chief Medical Officer for 1968*. London. H.M.S.O., 1969.

Are Antidiabetic Drugs Dangerous?

SIR,—I would like to associate myself with the attitude adopted in your leading article on this subject (21 November, p. 444). Basing its view on the findings of a multicentre trial, the American Diabetic Association recommends that insulin should be used where possible in mild maturity-onset diabetics not responding to diet or weight loss. Even if one accepts the validity of the findings that tolbutamide was associated with a significantly higher death rate from cardiovascular disease (and there are several compelling reasons for doubting this validity) the advice offered by the American Diabetic Association is illogical.

The results of the trial showed no difference in mortality between any of the groups during the first five years. As your leading article points out, there is evidence from other sources that within five years tolbutamide reduces the risks of cardiovascular disease.

The dose of tolbutamide (1·5 g. daily) was a high one, and, judged by the good diabetic control obtained in the placebo group, seems in any event to have been administered unnecessarily. All patients in this trial could have been controlled on dietary restriction without recourse to tablets or insulin. If this is not so the groups are not comparable.

There is no available evidence that the biguanides are associated with an increased mortality from cardiovascular disease. The mode of action of the biguanides is entirely different from that of the sulphonylureas. It is illogical to make recommendations for the use of both types of drugs on evidence obtained from tolbutamide alone.

The mortality rate from cardiovascular disease was slightly higher (though not significantly so) in the two groups treated with insulin than in the placebo group. Where is the logic for recommending insulin in this type of patient?

Even if the findings of the American multicentre trial are accepted the most that can be deduced is that long-term treatment with high dosage tolbutamide is unwise in subjects who can be adequately controlled by diet alone.—I am, etc.,

ARNOLD BLOOM.

London W.1.

Early X Rays

SIR,—Dr. E. Posner's interesting account of the "Reception of Röntgen's Discovery in Britain and the U.S.A." (7 November, p. 357) omits any reference to a paper[1] in which my late colleague J. F. Brailsford stated categorically that the first clinical application of *x* rays was made in Birmingham by two general practitioners—J. R. Ratcliffe and J. Hall Edwards. Ratcliffe's account of what happened in January 1896 is as follows.

"We met in Baynton's photographic shop