been caught off guard and try to sort ourselves out as quickly as possible. There is much to be done even though we find ourselves in a politically weak position.

I do not think it is fruitful to cavil at the permissive aspects of the legislation at present before Parliament. Many doctors will welcome the possibility of widening the grounds for abortion, but, as Dr. E. A. Gerrard said in the B.M.A. Committee, " no doctor would be obliged to violate his conscience " (22 January, *Supplement*, p. 19).

I think the energies of the B.M.A. can be most usefully spent in working to avoid any legislation which might end by limiting a physician's freedom of action. I am concerned that an amendment to Lord Silkin's Bill includes a system of notification for abortions. Such information will be readily available from the in-patient inquiry service without setting up a special system which could threaten a doctor's relation with his patient.—I am, etc.,

MALCOLM POTTS.
Sidney Sussex College,
Cambridge.

SIR,—In view of the report which you printed (*Supplement*, 22 January, p. 19) of the Special Committee on Therapeutic Abortion, the following points may be of interest:

(1) The Abortion Law Reform Association strongly opposes any special procedure of notification of medical termination of pregnancy for the following reasons: (*a*) adequate statistical information is already available from the hospital in-patient inquiry for all admissions, and this automatically covers termination of pregnancy; (*b*) each operating theatre in hospitals and nursing-homes is required to keep a comprenensive register of all operations performed, which provides a complete record; (*c*) inherent in all medical practice is a confidential relationship between doctor and patient which would be jeopardized by a special notification procedure.

(2) The Abortion Law Reform Association persists in its claim that specific provision must be made for medical termination of pregnancy where conception occurs before the mother is 16 years of age. The law is designed to protect girls under 16 against intercourse. It is inconsistent to do this and yet offer no specific relief from what can be the most disastrous consequence of such intercourse.—I am, etc.,

PETER DARBY,
Honorary Medical Secretary.
Abortion Law Reform
Association,
London S.E.11.

Cancer Education

SIR,—In your very interesting leading article (29 January, p. 247) on cancer of the corpus uteri you mention the great importance of treatment whilst still in an " early stage." You do not mention that the best way of achieving this is by educating the women.

When in practice, in common with other gynaecologists, I saw hundreds of women with irregular vaginal bleeding, and when asked why she did not come before the answer invariably was, " I thought it was only the change," sometimes backed up by the remark, " I talked to my neighbour and she said, ' Don't you worry, my dear, it is " only the change." I had to go through it.' "

For years my Cancer Information Association has been giving lectures to women's institutes and other women's organizations stressing the importance of irregular bleeding, and we distribute thousands of pamphlets for the same purpose.

I regret to say that occasionally it is the overworked general practitioner who tells his patient, " It is only the change," without examining her.

My association sends free leaflets to lay people who apply to the honorary secretary. —I am, etc.,

MALCOLM DONALDSON.
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Following up Cancer

SIR,—I have always supported the view that a diagnosis of malignancy should be concealed from the patient if possible. It is often said that patients have a right to know the truth, but I think they have a right to be spared the truth when the truth involves mental pain, because the infliction of mental pain is no more ethically justifiable than the infliction of physical pain. The question " Have I got cancer, doctor ? " almost always conceals a desperate plea for a categorical and convincing denial.

Even in cases carrying a good prognosis the wise clinician does not tell. But the patient's suspicions may be aroused during treatment, and the long follow-up period in out-patients is likely to convert suspicion into certainty. Reassurance will not be possible until final discharge from any further attendance.

I have in mind a case of carcinoma of the cervix treated successfully in London 15 years ago, and followed up afterwards every six months. For the past 12 years the patient—an intelligent woman—has been living in Bermuda, where the " follow-ups " followed her. She is still being examined every six months, and the long-drawn-out period of probation has coloured her whole life. Fifteen years may be an extreme example, but the same considerations must apply to much shorter periods.

I am well aware that surgical and radiotherapeutical progress demand the protracted follow-up of cases to assess results. But I wish there were some way of doing it without sacrificing the patient's peace of mind on the altar of the god of statistics.

There is irony in a situation where the patient is cured but is never allowed to believe it.—I am, etc.,

LUCY TURNER.
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Norfolk.

Death after Shipwreck

SIR,—Recent letters by Mr. H. B. Lee and by Dr. Sybil D. D. Jones and Mr. L. Bonvini (29 January, p. 295) raise the questions of how Channel swimmers survive their long immersion in cold water, and of what can be done to prevent shipwreck survivors dying of cold after rescue from the water.

Channel swimmers have an unusual amount of subcutaneous fat,[1] and since there is a close correlation between fat thickness and body cooling in water[2 3] there seems little doubt that they owe their survival to this.

The most useful steps that rescuers can take in small boats are probably to take the victim from the water as soon as possible, remove wet clothes, and replace them with dry blankets to prevent further heat loss from the body. Although there will no doubt be occasions when cooling would be slower if the victim were to be left in the water than taken out into very cold air, they must be very rare. Nor unfortunately do measures like rubbing the skin transfer enough heat to be of much value; they can in theory even do harm by increasing blood flow and so accelerating heat loss from the body core to the skin. Crews of larger rescue ships should clearly try to give severely chilled survivors an immediate hot bath, since there is strong evidence that this can save lives, and when possible it is advisable to take the blood-pressure at intervals during warming so that the patient can be tilted head down if it falls.

I can only agree about the importance of providing potential rescuers as well as potential victims with proper information on how to reduce the risk of death from immersion hypothermia. There seems no doubt that a considerable part of the large loss of life from this cause is avoidable. Though there are numerous official bodies on life-saving at sea it is often difficult for them to distribute such information to people who can use it, and informed advice from doctors could well be the most effective way of doing so.—I am, etc.,

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1 Pugh, L. G. C., and Edholm, O. G., *Lancet*, 1955, **2**, 761.
2 Keatinge, W. R., *J. Physiol.*, 1960, **153**, 166.
3 Cannon, P., and Keatinge, W. R., ibid., 1960, **154**, 329.

Vaccination Against Leprosy

SIR,—In his letter (22 January, p. 232) Dr. W. H. Jopling refers to the preliminary communication by Pettit and Rees[1] in order to assert that dapsone-resistant strains of *Mycobacterium leprae* already exist.

He does not, however, mention my letter[2] objecting to the interpretation of Pettit and Rees on the ground that it is by no means certain that dapsone acts directly upon *M. leprae*, if indeed we are even justified in the implication that this organism is a true bacterial species.

There is some evidence against a direct action of dapsone upon lepra bacilli. For example, during ten years' observation of many thousands of tuberculoid lesions in Nigeria—lesions from which mycobacteria were absent, or if present were so only in minute numbers out of all proportion to the cellular infiltrate—I noted differences in methods of healing.

Spontaneous healing of these lesions occurs as a centrifugal spread of repigmentation, whereas dapsone-induced healing is an almost uniform fading of the lesion—that is to say, a uniform recovery of pigment over the