asbestos fibres, which is just as important as the number.

F G MAYALL

Department of Histopathology,
Lancaster Moor Hospital,
Lancaster LA1 3JR

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Access to vital data denied

EDITOR,—I am evaluating the factors that contributed to the delay in the recognition and acknowledgment of the health hazard of exposure to asbetos dust and the consequent delay in the implementation of effective intervention. Scientists have had an important role in this history and in the study of dose-response relations—none more pominently than the members of the subcommittee on asbetos of the British Occupational Hygiene Society. The society's reports and related literature show that an account would be incomplete without a review of the data handled by members of this committee and of the details of their methods of working and decision making. This can be found only in their working papers, correspondence, and minutes, which extend over a quarter of a century.

In May 1990 I wrote to the president of the British Occupational Hygiene Society, requesting access to the files of the committee on asbestos. The reply stated that this was not possible on two counts: that there was no central archive and that much of the material had been made available on a confidential basis and it would not be acceptable for later councils to break that confidence. I wrote more recently to the society, requesting its permission for access to files containing its records that were preserved elsewhere, but I was informed that the society is still unable to allow anyone access to these data.

If commercial confidentiality ever applied to the data it must have lapsed after some 20 years and more. Medical confidentiality would never have applied to data from which individual subjects could not be identified.

This experience raises certain matters of principle in relation to scientific work and publication. Should it be a condition that data and analyses that have formed the basis of a publication be preserved and kept accessible for further study? What constraints of confidentiality are unacceptable in the field of scientific publication? If the accessibility of data constitutes part of the scientific ethic whose ultimate responsibility is it to ensure this—the author's or the editor's?

MORRIS GREENBERG

London NW11 7SY

Management of uncomplicated miscarriage

Randomised trials are possible

EDITOR,—We would like to address points raised by J B Sharma[1] and Lindsay F P Smith[2] with reference to medical management of first trimester miscarriage. Our pilot work has shown that medical methods achieve complete uterine evacuation in 95% of cases.[3,4] We are now recruiting 400 women into a prospective, patient centred, partially randomised trial comparing medical and surgical management with the main pragmatic objective of defining which treatment is best for which patient. We are aware, however, that early miscarriage has negative psychological effects for many women and that there is often dissatisfaction with several aspects of the care offered. The study considers these wider issues and aims to define the psychological responses to miscarriage objectively by using the hospital anxiety and depression scale to improve the information provided for these women and to define the most appropriate strategy for clinical follow up.

Medical treatment (whether for therapeutic abortion or miscarriage) requires a high degree of patient involvement, and the close care and support of nursing staff is vital. The study design chosen will allow us to assess the influence of patient preference.[5] Women without a preference are randomised to one or other method, whereas those with a clear preference are allocated to the treatment of their choice (resulting in four study arms). Of the first 125 patients, 19% have preferred medical treatment, 35% have preferred surgical treatment, and 46% have accepted randomisation. "Acceptability of treatment" was assessed at follow up by asking each woman which method she would choose in the future. At this stage, levels of acceptability are similar in all four study arms: "preferred medical," 92%; "preferred surgical," 95%; "randomised to medical," 93%; "randomised to surgical," 100%.

Women with inevitable or incomplete miscarriage are kept in hospital for 12-18 hours after starting medical treatment. Sharma expressed concern that only 57% passed products which could be examined histologically. Women with complete abortions, those managed at home by their general practitioners, and nearly all cases of therapeutic termination are also managed without access to histology. In all of the cases reviewed so far bleeding has completely settled at two week review. We agree with Smith that in cases of incomplete abortion where bleeding is not excessive the need for any treatment is debatable.

KIM HINSHAW KEVIN COOPER
RICHARD HENSHAW HAZEM EL-REFAEY
RACHEL RISPIN NORMAN SMITH
ALLAN TEMPLETON

University Department of Obstetrics and Gynaecology,
Aberdeen Maternity Hospital,
Aberdeen AB9 2ZD

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3 Henshaw RC, Cooper K, El-Refaey H, Smith NC, Templeton AA. Medical management of miscarriage: non-surgical uterine evacuation of incomplete and inevitable spontaneous abortion. *BMJ* 1993;306:894-5. (3 April.)
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Patients' safe with expectant management

EDITOR,—I was astonished to learn from Peter Macrow and Max Elstein's editorial that surgical curettage under general anaesthesia is the method of choice for managing inevitable miscarriage in Britain[1] and, from R C Henshaw and colleagues' paper in the same issue, that medical management is only now being investigated as an alternative.[2] I was further surprised to find that expectant management is not considered.

My practice, since 1976, has consisted entirely of the treatment of infertility and early loss of pregnancy. In the course of following up over 5700 pregnancies my colleagues and I have managed some 1200 inevitable abortions. Patients in whom a diagnosis of biochemical pregnancy, anembryonic pregnancy, or fetal death is confirmed by falling β human chorionic gonadotrophin concentrations or by ultrasound examination are offered a choice of immediate dilatation and curettage or expectant management unless dilatation and curettage is necessary to rule out an ectopic pregnancy. If they choose expectant management they report weekly by telephone until spontaneous miscarriage has occurred, at which time they are re-evaluated by ultrasound examination within 24 hours to determine whether the endometrial cavity has emptied completely.

If spontaneous miscarriage does not occur within three weeks the patients are brought back for ultrasound examination. In some cases the products of conception have been reabsorbed and can no longer be detected. In other cases the chorionic sac is still present and the decision to perform dilatation and curettage or to continue expectant management is reconsidered.

Patients who choose expectant management are given prescriptions: for painkillers, to be taken as needed for no more than 24 hours without examination by a physician; for antibiotics if needed for infection, to be taken for five days beginning at the onset of bleeding; and for an ergot alkaloid for use if needed when bleeding is heavy, to be taken only after consultation with a physician by telephone. In the event of heavy bleeding patients undergo dilatation and curettage in the usual manner. Such patients would not be candidates for mifepristone and prostaglandin either.

Most of our patients choose expectant management, and we know of no adverse outcome. Dilatation and curettage carries a risk of infection and even occasional perforation of the uterus, not to mention the risk of psychological trauma associated with admission to hospital. Its use should be given greater consideration, particularly in view of the potential side effects of surgical abortion and of treatment with mifepristone and a prostaglandin.[3,4]

RICHARD P DICKEY

Fertility Institute of New Orleans,
New Orleans, LA 70128,
USA

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Delaying appendicectomy overnight

EDITOR,—Rajendra Surana and colleagues' retrospective study found that delaying surgery for 6-18 hours did not significantly increase the rate of perforation, frequency of postoperative complications, or length of stay in hospital in children undergoing emergency appendicectomy.[1] Having undertaken a prospective study with eight year follow up of all patients undergoing appendicectomy in one health district in Merseyside over 12 months, we agree with the authors' main conclusions and present our own data to support similar findings in adults, but we take issue with the low rate of complications reported by the authors.

Of 248 patients (137 male, 111 female; median age 18 (range 6-18) years), number aged < 16 years 89) undergoing an emergency appendicectomy, 189 (76·2%) had histologically confirmed appendicitis; the organ was found to be perforated in 40 cases (21·2%). The proportion of perforated or inflamed appendixes increased with the time between admission and surgery (0-6 hours, 16/92 (17%); > 6-12 hours, 13/59 (22%); > 12-24 hours, 4/17 (24%); > 24 hours, 6/20 (30%); one missing value) but this did not reach significance ($p = 0·36$ (χ^2 test); 95% confidence interval −6·1% to 17·1%).