

other religious people, and since abortions, where done, must not exceed 25% of the total operations performed in a hospital, it is unlikely that her termination will be achieved.

This law is far from "abortion on demand" (even in spirit), and it was irresponsible of *The Lancet* to print such a statement.

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WOMEN IN MEDICINE

SIR,—Dr Roberts (July 8, p. 89) is concerned about the career structure available to women doctors. She suggests that they are under-represented as consultants and, when appointed, are more likely to hold the less sought-after positions, such as childhood mental illness.

I suggest that women doctors may have certain skills that men do not have and that we should be aware of these skills and make use of them and that we should value them as highly as the skills of men doctors. Women's virtues and qualities are not inferior but they are different. They have been described¹ as tolerance of weakness, sadness, and pain; patience, tenderness, sensitivity, and an ability to stand helplessness, despair, and inefficiency. This is in contrast to a man's dislike of weakness in himself and in others, his emphasis on competitiveness and efficiency, and his search for excellence. Women doctors often find expression for these skills in caring roles—work with children, anaesthesia, geriatrics, incurable problems, and incurable disease—and in feeling roles such as psychiatry, psychosomatic illness, and child guidance.

Possibly the two classes of doctors Dr Roberts describes are not so much élite and non-élite as appropriate to male or to female doctor skills. Consequently the 44% of appointments in childhood mental illness held by women doctors might be logical.

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OPERATORY

SIR,—You ridicule² the use of the word "operatory" in the Report of the Working Party on Training in Dental Anaesthesia. This term is common in North American dental literature and has the advantage that it distinguishes the practice of dentistry and the premises wherein it is performed, both of which are called "dental surgery" in the U.K.

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OESTRADIOL AND INDUCTION OF LABOUR

SIR,—Gordon and Calder³ have reported the beneficial effect of injecting oestradiol valerate suspended in a slow-release gel via a Foley catheter through the unripe cervix. They studied two groups of 25 patients and reported that cervical ripening was significantly improved in the group receiving oestradiol valerate 150 mg compared with the group treated with the gel alone, in whom there was very little change. 1 patient in each group went into spontaneous labour before planned induction.

Local oestrogens may have an effect on cervical collagen, thereby changing the physical properties of the cervix with the consequent benefits of a reduction in the duration of labour and in the need for caesarean section. In some species oestrogen

SUCCESS OF LABOUR INDUCTION AND CHANGE IN BISHOP SCORES BEFORE AND AFTER EXTRA-AMNIOTIC OESTRADIOL VALERATE

	Bishop score		Time to onset of established labour (h)	Insertion – delivery interval (h)
	At insertion	At first examination in labour		
<i>Successful (11)</i>	5.2 (3–8)	9.8 (8–13)	6.3 (1.5–10.5)	14.5 (6.0–22.8)
<i>Unsuccessful (4)</i>	4.0 (3–6)	5.8* (4–8)	† ..	† ..

† Assessed 24 h after injection; significant change (3–8) in only one patient.

† In the 4 unsuccessful cases the induction–delivery interval after amniotomy and intravenous oxytocin was 9.50 h (3.9–15.1).

dominance may indeed be associated with the onset of parturition besides having a possible local cervical action.

We have studied the effect of injecting oestradiol valerate extra-amniotically at a dose of 300 mg in a group of 15 unselected women requiring induction in an attempt to evaluate whether labour could be induced with this larger dosage and to assess any improvement in cervical status. Oestradiol valerate in alcohol was supplied in 24 ml viscous gel (4.5% methylhydroxyethyl cellulose, 'Tylose', MH 300), and injected approximately 5 cm through the cervix as a single dose via a urethral catheter, which was then withdrawn. The Bishop score, indicating cervical status, was assessed before injection and again after 24 h if labour had not started by then.

Labour was established in 11 out of 15 patients (74%). Stimulation of regular uterine contractions did not occur in the 4 patients who failed to go into established labour and in only 1 of these patients did the cervical status change significantly. The results are summarised in the table.

These results suggest an all-or-none response to the local application of 300 mg oestradiol valerate and are at variance with the controlled study using half this dosage reported by Gordon and Calder where cervical changes occurred without apparent stimulation.

We do not suggest that our results necessarily indicate a direct association between oestrogens and the onset of parturition. However, the all-or-none response experienced with labour induction suggests the necessary presence of some other factor or factors which facilitate the presumed triggering action of oestradiol. We were also interested to note the variable time interval seen between insertion of oestradiol and the onset of labour which again begs the question as to whether oestradiol does or does not have a direct influence upon the cervix.

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SPERM BASIC PROTEINS IN CERVICAL CARCINOGENESIS

SIR,—Dr Reid and colleagues (July 8, p. 60) correlate the protein chemistry of sperm with the socioeconomic status as an important aetiological factor in carcinoma of the cervix uteri.

Cervical cancer is rare among orthodox Jewish women, but the low incidence is not altogether accepted as being due to their husbands having been circumcised.^{1–4} Indeed non-Jewish women who admitted to coitus with circumcised partners had

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2. Wright, D. J. M. *King's Coll. Hosp. Gaz.* 1967, **46**, 261.
3. Plaut, A., Kohn-Speyer, A. C. *Science*, 1947, **105**, 391.
4. Kennaway, E. *Br. med. J.* 1955, **11**, 1107.