was systematically covered largely accounts for the fall now occurring in the number of cases of cervical cancer in Aberdeen. In the interests of economy, and in the light of our knowledge of the high-risk groups, should the taking of smears not become part of all routine antenatal care? The majority of cases would then be detected before the high-risk patient had finished childbearing. Twenty years later a fall in the incidence of the disease could be predicted, a fall which will never happen if only the well women offering themselves for screening and rescreening are covered.

J ELIZABETH MACGREGOR

Cytology Unit,
University Department of Pathology,
Aberdeen

Psychological sequelae of therapeutic abortion

SIR,—While I agree with the general tone of your leading article on this subject (22 May, p 1239), your statement that "comparisons between those aborted and those refused have shown little difference" needs clarification. The studies you quote in fact show quite serious sequelae in those refused, even though these are presumably subjects thought sufficiently healthy to be able to cope with their pregnancy. Combining the figures of Pare and Raven,¹ Clark *et al.*,² and Hamill and Ingram,³ 285 out of the sample of 597 were refused termination. Of those refused, 103 aborted (36%) and only 115 finally kept their baby (40%). Of 73 women who continued their pregnancy, Pare and Raven found that at follow-up 34% still regretted that termination had not been performed, while Clark *et al.* found that 7 out of 93 women who had been refused termination were mentally worse at follow-up compared with only one out of 111 whose pregnancy had been terminated.

It should be borne in mind that these figures are likely to under-estimate morbidity, since those who dropped out of follow-up are likely to have been the more unstable and these were almost entirely in the refusal group. Thus it is important that fear of psychological as opposed to physical sequelae should not restrict referral for abortion on psychological grounds.

J KELLETT

Department of Psychiatry,
St George's Hospital Medical School,
London SW17

¹ Pare, C M B, and Raven, H, *Lancet*, 1970, **1**, 635.

² Clark, M, *et al.*, *Lancet*, 1968, **2**, 501.

³ Hamill, E, and Ingram, I M, *British Medical Journal*, 1974, **1**, 229.

Effects of legal termination on subsequent pregnancy

SIR,—Mr J A Richardson and Professor G Dixon (29 May, p 1303) state that some patients referred to them from pregnancy advisory centres ask that their general practitioners should not be informed of their referral. They believe that "it seems reasonable to assume that these patients will not admit their termination during a future pregnancy."

As medical officers in the pregnancy advisory service from which these patients will have been referred we would like to make three points. (1) A patient's request that her GP should not be informed is infrequent and is not accorded to lightly. (2) All patients are told the

risks of termination to subsequent pregnancies and if it is agreed that the GP is not to be informed the importance of telling a subsequent obstetrician is stressed. (3) Patients who request that their GP should not be informed about termination sometimes make the request not because they wish to withhold the information from their doctor but because they fear that the information will become available to secretaries and receptionists.

We feel that there is no evidence that these patients will withhold the information from an obstetrician during a subsequent planned pregnancy.

RUTH E COLES
BERYL TULLY

Brook Advisory Centre (Avon),
Bristol

Flupenthixol for depression

SIR,—The letters from Drs J M Kellett and J P R Young (5 June, p 1405) highlighted fundamental differences in the models of depressive illness that are in current use.

I suggest that the presence or absence of "biological symptoms" in a patient complaining of depression is only one of many factors to be considered when making the diagnosis. Many patients with clearcut manic and depressive episodes, which make the diagnosis beyond reasonable doubt, do not show the biological disturbances of the classic syndrome of endogenous depression. In addition, many patients who are "dissatisfied with life" have "biological" complaints such as loss of libido or appetite.

Like Dr Kellett, I would like to know if flupenthixol is a useful alternative to amitriptyline for those patients who make a specific response to tricyclic antidepressants.

J H DOWSON

Seymour Clinic,
Swindon

Methysergide ineffective in spasticity

SIR,—Recent observations^{1 2} have suggested that L-5-hydroxytryptamine (5-HT) is a neurotransmitter in man. It seemed possible that spasticity could be due to pathological over-activity in neuronal systems using 5-HT as a transmitter. Since methysergide is a 5-HT antagonist a small open trial was conducted to assess whether this drug would reduce spasticity.

Informed consent was obtained from a small number of patients suffering from spasticity in the legs, due to various pathological processes, which had not responded to therapy with conventional agents. Spasticity was assessed by clinical examination at the knee joint and of gait. (In view of the negative results in this pilot study plans to measure spasticity quantitatively were abandoned.) Methysergide was given orally in an arbitrary dosage of 1 mg thrice daily for three weeks. No patient was taking other drugs known to affect

tone during this period. The patients had been selected carefully to ensure that there had been a fairly constant degree of spasticity for several months before the trial. This was therefore an uncontrolled trial.

The results are shown in the accompanying table. It can be seen that methysergide in the oral dosage used here had no significant effect on spasticity and did not benefit the patients. No side effects were encountered. Methysergide is therefore no substitute for the drugs currently available for the treatment of spasticity. One has to admit that this was a very small trial and that there was a rather varied pathology present. In view of the negative findings it would seem unlikely that the spasticity was due to an over-active 5-HT system, although this conclusion is certainly open to doubt.

G M YUILL

Department of Neurology,
North Manchester General Hospital,
Manchester

¹ Lhermitte, F, Marteau, R, and Degos, C F, *Revue Neurologique*, 1972, **126**, 107.

² Van Woert, M H, and Vimalah, S, *Neurology*, 1975, **25**, 135.

Homoeopathy

SIR,—Your issue of 15 May (p 1217) contained a review of Dr Margery Blackie's recent book, *The Patient, Not the Cure*.

The reviewer, trained presumably as an objective scientist, states: "The book makes it quite clear what rubbish homoeopathy is intellectually." This observation is made without any apparent clinical knowledge or experience of the discipline and so is surely a complete denial of objectivity. How can the reviewer explain away the physical benefits for patients in the five hospitals in Britain where homoeopathy is practised and the availability of its materia medica on prescription from general practitioners using homoeopathy within the NHS?

The increasing interest among veterinary colleagues is apparent in their membership of the Faculty of Homoeopathy. Farmers are very practical people; when their sick animals are improved and cured (as does happen) by homoeopathy, would your reviewer explain this to the farmer as being due to some charisma of the veterinary practitioner over the animal—or some mystical means of preparation of the medicine?

C K ELLIOTT

Royal London Homoeopathic Hospital,
London WC1

Oral lesions in tuberculosis

SIR,—I read with interest the case report by Mr P G McAndrew and others (29 May, p 1320) and would like to emphasise a number of points.

Although it is now a much less common disease in Britain, patients are still presenting with tuberculosis in late stages.¹ The lesions are now less easily recognised as they can mimic

Patient	Age (yrs)	Diagnosis	Features	Result of therapy
1	59	Multiple sclerosis	Spastic paraparesis	Doubtful benefit
2	53	"	"	No change
3	71	Cervical spondylosis	"	No change
4	32	Jamaican neuropathy	"	No change
5	69	Cervical spondylosis	"	No change
6	67	Cerebrovascular disease	Left hemiparesis	No change

many other oral lesions and rarely is tuberculosis at the top of the list of differential diagnoses.² In the older texts, when tuberculosis was more common, the ulcers were described as being painless and found mainly on the tongue and occasionally on the gingivae. Patients seem to be taking longer to seek advice for such lesions and the pain is probably related to further infection of the ulcer with normal oral commensals.

Finally, I would stress that, although this case was reported from Nigeria, such cases are still to be seen in Britain in both natives and immigrants, and the incidence may be even higher than is thought, as oral lesions are rarely sought in patients with active tuberculosis. Such patients with covert tuberculosis and dental pain may well be given a general anaesthetic during treatment and investigation, with the resulting danger of infecting the anaesthetic apparatus.

IAIN LAWS

Dental Department,
Royal Free Hospital,
London NW3

¹ British Thoracic and Tuberculosis Association, *Tubercle*, 1971, 52, 1.

² Laws, I M, *British Dental Journal*, 1973, 134, 146.

Genetic counselling in Huntington's chorea

SIR,—We are concerned at the increasing publicity and the changing attitudes towards genetic counselling in Huntington's chorea. Under the guise of "help" a major drive is developing to discover all the families with the disease.

Before all this becomes too public, and therefore out of the control of medical ethics, we feel several points need to be emphasised. (1) It is a rare disease which has involved a few families for many generations. (2) To eradicate the disease from a family the family itself must be eradicated. This is idealistic medicine, but is it the best medicine here? (3) The only "help" that can be given at present is advice against having children. (4) Particular gentleness and care are needed in genetic counselling in these families because one is advising people who have not yet displayed symptoms of a disease they may have inherited. The foremost responsibility of doctors is towards living patients and not possible future generations. (5) In some patients the disease is not as terrible as is usually described. This should not influence genetic counselling but is a useful solace when advising those at risk. There seem to be familial traits in the clinical picture. In a family which we have studied seven out of 20 members have had mild chorea with no dementia for many years. The average age at death of affected members in that family has been five years older than that of the unaffected members in the last three generations. Therefore we suggest the following: (1) Only doctors should be made aware of this disease, otherwise there is a danger of the general public becoming over-involved. Chorea-hunting and persecution of witches in choreic families was common in America last century.¹ This was done in the name of religion. We do not want a recurrence in the name of genetic counselling. For this reason we suggest that the use of the media to publicise Huntington's chorea is foolhardy. (2) Affected families should be approached through their general practitioners, who are the only professional people in a position to

advise which members of a family should or should not be contacted.

G M GLENDINNING
N W GLENDINNING

South Petherton,
Somerset

¹ Vessie, P R, *Journal of Nervous and Mental Diseases*, 1932, 76, 553.

Outpatient laparoscopic sterilisation

SIR,—I note with interest Mr J H Brash's conclusion (5 June, p 1376) that in his hospital outpatient laparoscopic sterilisation has proved highly acceptable to both patients and staff. I would like to sound a cautionary note from the anaesthetic viewpoint.

Since laparoscopy was first performed on dogs by Kelling¹ in 1902 the deliberate production of a pneumoperitoneum with carbon dioxide has been constantly observed to result in a decrease in the patient's tidal and minute volumes, an increase in arterial carbon dioxide tension, a decrease in cardiac output and central venous pressure, and the possibility of silent regurgitation of stomach contents. These problems led Hodgson *et al*² to conclude that the anaesthetic technique should include controlled hyperventilation via an endotracheal tube and that laparoscopy should not be regarded as yet another minor procedure.

My own experience bears out their views, and indeed authorities such as Lee and Atkinson³ state that controlled ventilation is mandatory during anaesthesia for this procedure. Since the use of muscle relaxants is contra-indicated in day-case anaesthesia I would suggest that it is, to say the least, doubtful if laparoscopy should be undertaken on a day-case basis.

R H JAGO

Anaesthetic Department,
Cambridge Military Hospital,
Aldershot, Hants

¹ Kelling, G, *Münchener medizinische Wochenschrift*, 1902, 49, 21.

² Hodgson, C, McClelland, R M A, and Newton, J R, *Anaesthesia*, 1970, 25, 382.

³ Lee, J A, and Atkinson, R S, *Synopsis of Anaesthesia*. Bristol, Wright, 1973.

Prevention of coronary heart disease

SIR,—Dr M A Crawford's belief (19 June, p 1532) that degeneration of human coronary arteries is caused by the intensive feeding of farm animals finds no support at all in the facts of agriculture. Stall-fed animals make up only a very small proportion of the total population of cattle and sheep, which graze on fields and hills. In dairy herds the tendency has been an increased dependence on grass feeding. In England and Wales¹ from 1949 to 1969 the consumption of concentrates per cow rose by only 153 kg; during the same period the figure for silage was 742 kg. In any case, according to Dr Crawford's own figures² the most underexercised and intensively fed of all domestic animals, the pig, has a far higher percentage of unsaturated fat than the beasts which roam the fields.

The last paragraph of Dr Crawford's letter is wholly incomprehensible and I suggest to him that before writing to the press he might at least read that which he seeks to criticise. He attributes to me advocacy of "sugary saturated high teas" and implies that I am uncaring about the health of future generations.

Unlike Dr Crawford, who has no clinical experience and who works among animals, I live and work among people; they are my friends as well as my patients. For over 25 years I have observed their diseases, their way of life, and their nutrition, and like most general practitioners I share in their agonies and ecstasies. Because I care a great deal about the dreadful effects of the high incidence of diseases such as dental decay, obesity, coronary heart disease, peptic ulcer, diabetes, diverticular disease, and, above all, cancer I have repeatedly campaigned³⁻⁵ against those "sugary high teas" which are so popular in Scotland and which I believe are the cause of these very diseases. Any possible "saturation" of my high tea will be corrected by the wheat germ oil in my whole-wheat bread.

Coronary heart disease is, I am convinced, but one wave in a whole tide of degenerative diseases which, since the turn of this century, has steadily risen in industrial societies. Changes which have occurred in the quantity or quality of fat cannot, in my opinion, explain this pattern of disease. I am sure, however, that, in elaborating the role of refined carbohydrate foods as the cause, the work of Cleave⁶ will stand as a landmark in human affairs.

WALTER YELLOWLEES

Aberfeldy,
Perthshire

¹ Morton, J, Milk Marketing Board, 1971. Personal communication.

² Crawford, M A, *Lancet*, 1968, 1, 1329.

³ Yellowlees, W W, *British Medical Journal*, 1960, 1, 125.

⁴ Yellowlees, W W, *British Medical Journal*, 1964, 2, 1332.

⁵ Yellowlees, W W, *British Medical Journal*, 1976, 1, 401.

⁶ Cleave, T L, *The Saccharine Disease*. Bristol, Wright, 1974.

Once-daily treatment of hypertension

SIR,—Drs A P Douglas-Jones and J M Cruickshank (24 April, p 990) claim atenolol to be effective in once-daily dosage in controlling blood pressure in patients with mild or moderate hypertension. However, their conclusions appear to be drawn from an analysis of evening blood pressure readings taken once every two weeks and as a result no information is available concerning within-day blood pressure variation; also their patients did not perform an exercise test.

I have undertaken a pilot study to determine whether once-daily therapy with the beta-blocking drug sotalol would have a satisfactory 24-hour effect in lowering blood pressure in eight patients suffering from mild to moderate hypertension. The pharmacokinetics of sotalol and its relatively long plasma half life of 12-7 hours¹ suggested its use for this purpose. Blood pressure and heart rate were measured in each patient's home at 7 pm, 11 pm, and 7 am. On each occasion recordings were made at rest in the lying and standing positions and repeated after three minutes' exercise. After a 4-day run-in period once-daily therapy with 80 mg of sotalol taken just after 7 am was commenced. Dosage was increased until a satisfactory reduction in diastolic pressure, measured on the above thrice-daily schedule, was achieved. Readings were then taken weekly for a further six weeks with the same thrice-daily routine.

Preliminary analysis of the results shows the following features: (1) Beta-blockade with sotalol showed a dose-response relationship. Blood pressure was reduced by 12-20 mmHg.