preserved, whereas putting him into a warm bed was certain destruction."—I am, etc.,

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## Treatment of Choriocarcinoma

SIR,—In their article on the treatment of choriocarcinoma (4 March, p. 521) Professor W. S. H. Tow and Mr. W. C. Cheng contend that hysterectomy should be used more often than it nowadays is, particularly in specialized centres, for the treatment of "trophoblastic malignancy." Current evidence suggests that hysterectomy is being performed in this context (*a*) if the uterine wall becomes perforated, (*b*) if the site of a focus of drug-resistant malignant trophoblast is suspected to be within the uterine wall, and rarely if at all otherwise.

Clearly, useful discussion on "trophoblastic malignancy" or "choriocarcinoma," including arguments for and against hysterectomy, is possible only if those who use these terms mean the same thing by them. The range of meaning given to the term "choriocarcinoma" by Tow and Cheng would in fact be endorsed by few other students of trophoblastic disease. A distinction has long been made for prognostic purposes between neoplasia of trophoblast which is associated with persistence of chorionic villi and a relatively good prognosis (usually with hydatidiform mole of whatever type), and neoplasia of trophoblast which is associated with absence of chorionic villi and relatively poor prognosis (the usual connotation of choriocarcinoma). This distinction is of value but has not been admitted into their analysis of results by Tow and Cheng. To many workers their designation "villous choriocarcinoma" is a contradiction in terms; it is likely to cause confusion and certainly complicates assessments of the incidence and treatment of choriocarcinoma. By including in their series of 80 cases of "choriocarcinoma" 27 that were of the "villous" type they are including 27 cases that would certainly not have been called choriocarcinoma in most other centres. Their figures for cure rates thus become debatable and require close examination. This, however, is not possible, since we are not told what the results of therapy were, separately, for their three categories of "choriocarcinoma": *villous* (*not* regarded as choriocarcinoma in most centres), *clinical* (diagnosed on indirect evidence), and *non-villous*. This is a serious deficiency, and we would hope that a more detailed supplementary analysis will soon be made available, perhaps in terms of the simple classification of trophoblastic neoplasia recently proposed by the International Union against Cancer[1] and now being used increasingly widely—namely, hydatidiform mole (*a*) non-invasive, (*b*) invasive; choriocarcinoma; and morphological diagnosis uncertain. This would enable the results of therapy as recommended by Tow and Cheng to be compared with those obtained in other centres, a comparison that cannot be made meantime on the data they provide.

Further, it is difficult to deduce from the following passage exactly what the criterion is that determines the decision whether hysterectomy should be performed or not: "Hysterectomy was performed in patients . . . whose uteri were thought to harbour a malignant growth. It was withheld in young nulliparous patients and in those with extensive metastases." If hysterectomy is considered to be the optimum treatment for a malignant growth it should surely be performed no matter what the age or parity of the patient (there is no evidence that choriocarcinoma is *less* dangerous at younger ages or lesser- or nulli-parity); if, on the other hand, the reason for its *not* being performed is the state of parity treatment of the malignant growth is being relegated to second place. Removal of a neoplasm-bearing uterus may indeed be regarded for supplementary reasons of convenience as the treatment of choice—in the multiparous and/or older patient, or to remove for ever the possible discomforts of uterine disease of whatever kind—but, if this be the argument, it is essentially for these reasons that hysterectomy is being chosen, not because it is the best treatment for choriocarcinoma. Indeed, in stressing so often the desirability of retaining the uterus in the nulliparous patient, Tow and Cheng are in effect implying that the optimum treatment for choriocarcinoma per se is, after all, chemotherapy.

In conclusion, two matters of pathology may be mentioned. Firstly, the authors have made no distinction between metastasis of villi from a hydatidiform mole and metastasis of choriocarcinoma; these are quite different lesions and should not share the same unqualified designation. Secondly, the term "a trophoblast," to indicate a type of cell, should not be used—there are Langhans' or cytotrophoblastic cells, and syncytial or syncytiotrophoblastic cells, but no "trophoblasts."—I am, etc.,

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## Drugs and Thyroid-function Tests

SIR,—Mr. J. M. Baron (18 March, p. 699) draws attention to the effect of chlordiazepoxide (Librium) on tests of thyroid status. Recent experience in this department agrees with his finding of a depressed thyroid uptake of $^{131}I$ in patients on chlordiazepoxide. In addition, we have found that the related drug diazepam (Valium) has a similar effect. As these two drugs are now very popular in the treatment of anxiety and emotional disorders, it is often found that patients referred with suspected thyrotoxicosis are taking one or other. It is therefore surprising that this effect has apparently not been described or publicized before.

In the last month 80 patients attended this department for tests of thyroid function, of whom 26 (33%) were taking drugs of some kind. Ten of these patients were on psychotropic drugs, and of these four were taking diazepam and three chlordiazepoxide. None of the patients on these drugs who were thought on clinical grounds to be thyrotoxic had raised uptakes of $^{131}I$. Two were in the low normal range, and one was well into the hypothyroid range, this figure being obviously incompatible with his true status.

Although this number of patients is small, it is obvious that there must now be a great many patients on diazepam or chlordiazepoxide who are referred for $^{131}I$ uptake tests. A normal result in these circumstances does not exclude hyperthyroidism, and it is to be hoped that this will soon be more widely known.—I am, etc.,

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SIR,—We were interested in the letter by Mr. J. M. Baron (18 March, p. 699) suggesting that chlordiazepoxide may act as an antithyroid drug and interfere with thyroid function tests. In fact, there is experimental evidence for this in animals[1 2] and its use has been suggested as an adjunct in antithyroid drug therapy.[3] Phenothiazines, also, have been claimed to modify function tests in man.[4–6]

It is our clinical experience that chlordiazepoxide and diazepam are of value in combating many of the manifestations of thyrotoxicosis, but it is impossible to say whether this is due to a specific action on the thyroid gland rather than to their tranquillizing effect.—We are, etc.,

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## Psychiatric Sequelae of Termination of Pregnancy

SIR,—Both Dr. M. D. Enoch and Dr. M. Sim (4 March, p. 563) call for more facts and less fiction about the sequelae of termination. We heartily agree. One of us has repeatedly[1–3] drawn attention to the Scandinavian literature, which is distinguished by its thoroughness and by its critical approach, and can hardly be discounted as propaganda. This literature, we believe, provides the psychiatrist with the basis for an informed opinion when he has to decide between the various possible courses of action.[3] Neither of us has ever claimed more than that termination on psychiatric grounds is an effective treatment in selected patients.

In reply to Dr. Enoch's rather cynical remarks, if the same facts are being interpreted differently, this is not necessarily due to "distortion" or to political aspirations, but to the complexity of the problem, to the absence of strictly comparable controls, and perhaps most of all to differences in the degree of "proof" thought desirable to justify the sacrifice of the embryo. The comprehensive study by Ekblad[4] shows that from the medical standpoint the results of therapeutic termination are so good that they would be hard to match in any other definable psychiatric group. Ekblad states: "The majority of women had been only satisfied with and grateful for the operation and had not had any depression or demonstrable impairment of their psychic health through the abortion." The inexperience of the tribunals, remarked on by Dr. Sim, suggests to us that, with improved selection, even better results could be obtained. When we wrote (4 February, p. 299) that the results were excellent in "stable women," of