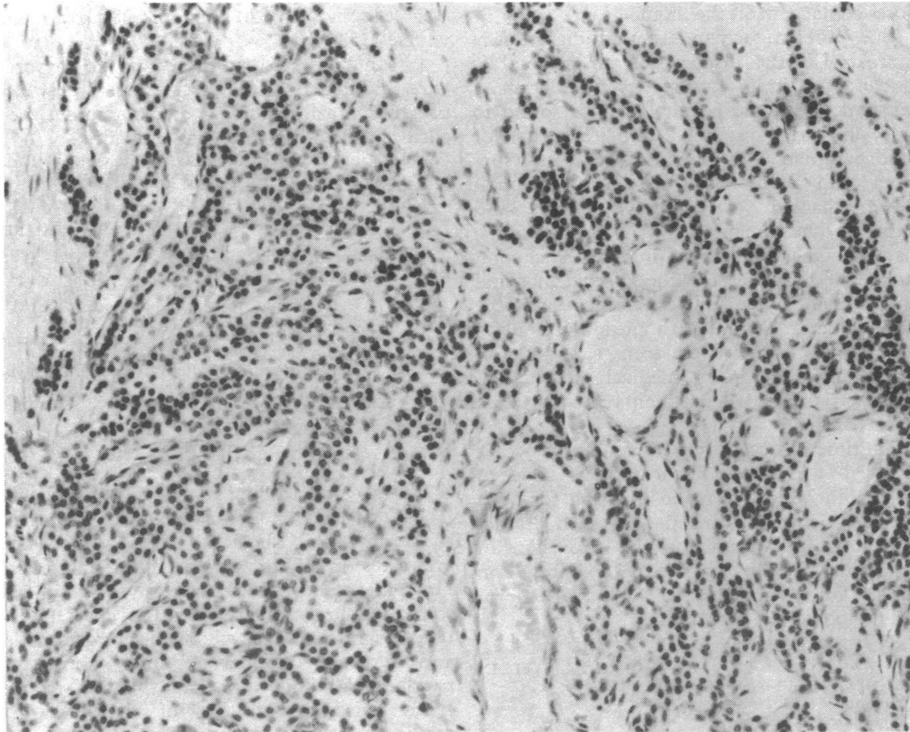

Woman aged 66. Metastatic glomus tumour in hilum of a juxta-aortic lymph node. The tumour cells in infiltrating the tissue have oriented themselves to the blood vessels in a manner immediately reminiscent of the relation between glomus cells and vasculature in normal glomera and in glomus tumours (glomangiomas) as they are ordinarily seen. Although not well seen at this magnification, the tumour cells have the features of glomus cells, with rather small deeply stained nucleus and distinct but relatively narrow cytoplasmic rim. (Haematoxylin-eosin. × 160.)

tainly no justification for categorizing all glomus tumours as hamartomatous as, regrettably, I must admit to having done elsewhere.[3]

The interpretation of the histological picture in these cases is admittedly debatable, if not controversial. Nevertheless, it cannot be maintained that they are all misinterpreted instances of "haemangiopericytoma," Kaposi's sarcoma, or other accepted varieties of angiosarcoma, or of lymphosarcoma or secondary carcinoma, though I have heard such explanations put forward by specialists in diagnostic tumour pathology. On the other hand it may be remarked, without malice but echoing the timely admonition in your leading article, that the cause of those who would shed light on these problems is not helped by the runaway enthusiasts who support their contention of the occasional malignancy of glomus tumours by citing published references to malignant examples of chemodectomas, some of which arise from the glomus jugulare and other "glomera" that have nothing whatever to do with the totally different glomera in the skin and some other situations that are the origin of the tumours generally known as "glomus tumours." I would stress that these strictures have no direct bearing on your leading article; it is with its contention that a glomus tumour is necessarily a benign tumour that I take issue.—I am, etc.,

WILLIAM ST. CLAIR SYMMERS, SEN.

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1 Lumley, J. S. P., and Stansfeld, A. G., *British Medical Journal*, 1972, 1, 484.
2 Willis, R. A., *Pathology of Tumours*, 4th edn., p. 651. London, Butterworths, 1967.
3 Symmers, W. St. C., in *Systemic Pathology*, ed. G. Payling Wright and W. St. C. Symmers, vol. 2, p. 1561. London, Longmans, 1966.

Latent Morbidity after Abortion

SIR,—Dr. D. M. Potts (24 March, p. 739) states that the Karman catheter is becoming popular in many centres and quotes figures published in 1971 by Beric and Kupresanin[1] from Yugoslavia. Dr. Potts has overlooked the paper by these authors, together with Dr. J. F. Hulka, published in September 1972,[2] in which they describe their clinical trials of the Karman catheter. In this paper they say that to the best of their knowledge no previous results of clinical trials of this catheter had been published. The trials described covered 322 patients. After using the Karman catheter retained products of conception were found in 12% of all pregnancies of six weeks' gestation, 47% at seven weeks, 85% at eight weeks, and 100% of pregnancies of over eight weeks' gestation. The authors concluded: "We felt the catheter offered the advantage of no dilatation and anesthesia for most early pregnancies but was not suitable for terminating pregnancies beyond the sixth week of gestation."

We are grateful to Dr. Potts for drawing our attention to a recent Hungarian paper. May we draw his attention to the long series of papers on the sequelae of induced abortion in *Československá Gynekologie,* including many data on first- and second-trimester spontaneous abortions, prematurity, and sterility following previous terminations, and to the report in that journal[3] of a national conference on the sequelae of abortion? There is a similar series of papers in a journal of the Romanian Academy of Sciences, *Obstetrica şi Ginecologia.* It has never been explained clearly to English readers just why, after liberalizing abortion for some years, the Romanians decided to reimpose heavy legal restrictions. The assumption that this change of policy was made only on demographic grounds much underestimates the influence of the Romanian medical profession. It is now proposed in Romania that a previous "curettage" should be one of the main factors to be given a numerical value in computing a risk index for pregnancy to help antenatal care.[4] It was one of our recommendations to the Lane Committee that this substantial literature should be reviewed and we explained in our preface that we had covered only a fraction of what is available.

We disagree with Dr. Potts on one point. He expresses concern at the distress caused to women who have had an abortion by knowledge of the possible sequelae. If a woman who has had an abortion conceals this fact from her obstetrician in a subsequent pregnancy she reduces her chances of a successful outcome. She may best be persuaded to confide in him by being made aware of the risks. Knowledge of the less fortunate consequences of our actions is part of the substance of health education; it may be painful, like the knowledge of the morbid consequences of smoking to smokers. The spread of such knowledge is an essential part of primary prevention. We consider that knowledge about the latent morbidty that follows induced abortion is an important part of the case for the responsible use of contraception and of education for parenthood.—We are, etc.,

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London N.6

1 Beric, B. M., and Kupresanin, M., *Lancet*, 1971, 2, 619.
2 Beric, B. M., Kupresanin, M., and Hullal, J. F., *American Journal of Obstetrics and Gynecology*, 1972, 114, 273.
3 *Československá Gynekologie*, 1970, 35, 325.
4 Sirbu, P., *Obstetrica şi Ginecologia*, 1972, 19, 743.

SIR,—It may be worth pointing out that the Yugoslavian statistics cited by Dr. D. M. Potts (24 March, p. 739) do not in fact provide any unequivocal support for his conclusion that outpatient abortion under paracervical block does not increase the prematurity rate for subsequent pregnancies, in contrast with the situation in Hungary, where increased prematurity after abortions induced by dilatation and curettage under general anaesthesia is well attested.

What Dr. Potts shows is that legal abortions in the Novi Sad hospital increased from 4,580 in 1960 to 6,445 in 1970 and that there was no significant increase in the prematurity rate for deliveries over the same period. But the figures as they stand give no information about the induced abortion rates for mothers later delivered of live babies. Has Dr. Potts any evidence that these increased over the 10 years? If so, then his conclusions about prematurity and ectopic pregnancy rates may be justified —but otherwise not.—I am, etc.,

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Treatment of Spina Bifida Cystica

SIR,—In your recent leading article (10 March, p. 565) you state that "the problem of what treatment should be offered was pre-

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