Pott's Paraplegia

SIR,—In your leading article on Pott's paraplegia (15 June, p. 638) you state that "The classical condition described by Pott is a paraplegia of early onset, in which pressure is due to tuberculous pus, granulation tissue, and necrotic material." This statement is, I fear, incorrect. Pott in his monographs entitled "Remarks on that kind of palsy of the lower limbs which is frequently found to accompany a curvature of the spine and is supposed to be caused by it"[1] and "Further remarks on the useless state of the lower limbs, in consequence of a curvature of the spine"[2] described paraplegia associated with spinal deformity. He said nothing about early onset, he did not know that the disease was tuberculous; he therefore made no mention of tuberculous pus. No reference to granulation tissue or to necrotic material will be found in any of Pott's writings on the paraplegia in question.

The fact that Pott's disease is a manifestation of tuberculosis, though surmised by earlier writers as a possibility, was not really established until the writing of J. M. Delpech.[3]—I am, etc.,

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3 Delpech, J. M., *De l'orthomorphie*, 1828. Paris.

Anencephalus and Spina Bifida

SIR,—In your leading article on anencephalus and spina bifida (16 March, p. 660) you state: "When the series was divided according to religion it was found that Roman Catholics had the highest incidence of both malformations . . . Protestants came next . . . and Jews last. . . ." You also state that the high figure for the Catholics could be accounted for by the fact "that a substantial proportion of these families had their origins in Ireland."

I published a paper[1] on the prevention of anencephaly and foetal abnormalities by a preconceptional regimen in which I suggested that these conditions may be prevented by alteration in the frequency and timing of intercourse, and I showed significantly successful results by the application of a preconceptional profertility regimen. At the Rotunda Hospital 99% of the patients are Catholics. In the infertility department of the hospital for many years we have selected cases of repeated abortion, repeated miscarriages, and repeated foetal abnormalities with no live babies. We have applied to these cases our preconceptional profertility regimen, which basically involves restricting the frequency of intercourse and confining it to ovulation dates. Significantly successful results have been achieved in what would otherwise be hopeless cases, and these have been published in the annual reports of the hospital and elsewhere.[1-3]

Emil Witschi states[4]: "Reviewing nature's own ways of fertility restriction, one cannot without mention pass by the claim that calculated rhythmic abstinence by man should also be valued as a 'natural' control method. Unfortunately it is based on a misinterpretation of human sex physiology. In lower vertebrates and wild bird sex drives and reproduction as a rule are seasonally restricted. In many mammals cycles of shorter duration have been established. The females then become receptive and attractive to the males only during a relatively short period, the 'heat' coinciding with ovulation time. However, the corresponding human cycle is circadian. Recognition of ovulation time is lost but the gain of this evolution is that it keeps males and females constantly interested in each other, thereby creating a basis for close and durable family life. The abstinence method opposes nature's intentions by setting up a new rhythm, bi-weekly alternating 'les plaisirs du vice, et les honneurs de la vertu' (Rousseau). Not only disregarding a powerful psychophysiologic component of adult sex life, its practice also endangers the quality and wellbeing of the offspring. If the 'safe period' is not conservatively observed or when ovulation is retarded chances are that fertilization may occur after its optimal time has passed and when a waiting egg has become overripe.

"It is now a well established fact that delay of insemination causes deterioration of vertebrate eggs with consequent chromosomal abnormalities, polyspermy, and teratologic development. Intrafollicular and postovulatory over-ripeness can clearly be recognized as a major cause of the relatively high incidence of malformations in early human embryos and fetuses."[5,6]

Orthodox Jewry imposes strict observance of Niddah, which is complete abstinence from intercourse for seven days after the last day of a period. In Orthodox Jewish marriages, therefore, intercourse does not take place or does not start to take place until the woman is ovulating. It seems reasonable to assume that the low incidence of anencephaly amongst Jews could be explained by the practice of Niddah. It is also reasonable to assume that the "rhythm" method of family planning which is common in all Catholic countries could be blamed for the high incidence of anencephaly and foetal abnormalities in Catholic populations.—I am, etc.,

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Nasal Cancer in Woodworkers

SIR,—The commendably thorough study of nasal cancer in woodworkers in the furniture industry by Dr. E. D. Acheson and others (8 June, p. 587) prompted a fresh look at the data on nasal cancer in Canada.[1]

Crude and age-adjusted death rates are difficult enough to interpret for any cancer with a possible latent period of 40 years, and in Canada there are the added factors of a mobile labour force in a rapidly changing industrial scene, and a population more than doubling its numbers in this time interval. Nasal cancer deaths in woodworkers were therefore tabulated by province, and their distribution was compared with that of the woodworkers among the original controls. These were death certificates, matched for age and year of death and province with all the deaths from nasal cancer in 1956–65. This allows for the irregular distribution of woodworkers, and would be expected to show up any provincial increase in risk of nasal cancer in that occupation, unless woodworkers have an additional unforeseen risk of dying of some other cause. This analysis does not show anything of note (Table I).

Next, the furniture makers were separated from the carpenters (Table II). Of the 28 woodworkers with nasal cancer there were only two furniture makers (aged at death 68 and 80) and of the 24 controls there was only one. All were Ontario residents.

Hardwood furniture manufacturing is only a very small part of the Canadian wood industry. It is centred in Ontario and Quebec, and uses birch, maple, oak, walnut, poplar, cherry, and mahogany. Other woodworkers can be considered to have worked with Douglas fir, hemlock, western pine, red cedar, and western white spruce in the west, and with eastern spruce, red pine, white pine, jack pine, and eastern hemlock in the east.

Thus the negative findings in the Canadian woodworking industry appear to be consistent with the conclusion of the United Kingdom workers, who found the hazard restricted to furniture workers.—I am, etc.,

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TABLE I.—*Distribution of Nasal Cancer in Woodworkers Across Canada*

Province	B.C.	Alta.	Sask.	Man.	Ont.	Que.	N.B.	N.S.	P.E.I.	Nfld.	Total
Cases	4	1	2	1	7	5	3	2	1	2	28
Controls	3	0	2	1	9	5	1	3	0	0	28

TABLE II.—*Distribution of Nasal Cancer Among Woodworkers*

Group	Furniture Makers	Carpenters (Menuisiers)	Lumbering Logging Sawyers	Wood-merchant Forestry Contractor	Total
Cases	2	14	11	1	28
Controls	1	13	9	1	24

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1 Ball, M. J., *Lancet*, 1967, **2**, 1089.