SIR,—Dr. P. Moxon (11 March, p. 693) draws his inferences from very tenuous reasoning. Neither I nor, I believe, any of the other doctors who signed the doctors and overpopulation letter (8 January, p. 108) would wish the emphasis to shift from prevention to termination of pregnancy. Before the Abortion Act is made the scapegoat for the increased number of handicapped children, Dr. Moxon should remember that in the 12 years before the Act was passed the numbers of educationally subnormal and mentally handicapped children almost doubled. (These figures are taken from "Family Planning and Population Control," a paper read by Dr. R. D. Haigh at the 4th Biennial Conference of Maternity Liaison Committees in the Sheffield Regional Hospital Board Area on 16 November 1971.)

To say that the United Kingdom would have a falling population by 1974 if present trends continue ignores the Registrar General's return for the quarter ending 31 March 1970. This points out that 70% of all births in the United Kingdom occur to women aged 20-29. The numbers of these potential mothers in 1981 and those at the most fertile ages in 1991 can be predicted with some confidence. Table 3 on p. 53 shows that there will be a 20% increase in 1991 and a 23% increase by 2001. "This increase in the population of women means that unless a very substantial and quite unforeseen fall in fertility rates should occur, the number of future births will show a rising trend, a little more sharply in the 1980s than in the 1970s."

As to his warning about an increased dependency ratio, of course we realize that a falling population means that for a period of 50 years there will be a relative increase in the over-65 age group. This is a small disadvantage compared with the eventual results of an ever-expanding population. For a nation that twice within a lifetime has sent its young men to die in their hundreds of thousands, it would seem to be a relatively trivial burden to face.—I am, etc.,

P. J. HORSEY

Compton,
Winchester, Hants

SIR,—Dr. P. Moxon (11 March, p. 693) raises a number of points. The birth rate has been dropping and stood at 16.2 in 1970. This indeed is below the rate for 1931, but there is no consideration of the death rate at that time. Our death rate now is about 12; in the 1930's it was about 16—that is, replacement rate. Consequently our present birth rate must approach 12 before the population will stabilize. With a birth/death rate of 16/12 our population will continue to grow at about 0.4-0.5% per year. If this, say, were reversed and our population allowed to decline at the same rate the proportion of active, working people would be exactly the same as now. (It is not only the old who need support—children are also very dependent members of the population.) In addition many over 60s, now required to retire, could continue active, useful lives. (Incidentally, as a post-script, the 1971 birth rate announced recently shows an increase over 1970.)

The original signatories (8 January, p. 108) of which I am one, did not propose political control of population. What I, and I'm sure the others, want to see are the

facts laid simply and understandably before the public. Given this type of education and the wherewithal to voluntarily limit family size then much, and possibly all of the problem in these Islands would be solved without such political control. Since a massive educational programme is the linch-pin of this type of action then Dr. Moxon's point that only the educated will respond can be seen in a somewhat different light.

With an increase in public knowledge, plus increased availability of contraceptive methods, it is likely that the abortion rate will drop and not "have to rise to about 400 per 1,000 births to eliminate population increase." Prevention is better than cure.—I am, etc.,

JAMES BRIGGS

Department of Pathology,
Frenchay Hospital,
Bristol

Donors for Organ Grafting

SIR,—Your leading article on donors for organ grafting (4 March, p. 582) concluded by saying: "There is, however, an urgent need for more organs, and these might be available if the medical profession and public were more aware of the lives that could be saved by donations from the dead."

I have been requested to carry out a survey to estimate the possible number of donors for organ grafting which could have been made available in one year in a typical peripheral hospital. The preliminary findings at this hospital for the year 1971 were a total of 190 deaths. Of these, 13 could have been suitable candidates. Their ages ranged between 15 and 59 years, the average age being 43. Six of these cases had to be ventilated and subsequently ventilation was discontinued. The cause of death: intracranial haemorrhage, 5; head injuries, 3; brain tumour, 1; overdoses, 2; brought in dead, 2 (died approximately 10 minutes before arrival and certified dead. Subsequent necropsy showed coronary occlusion but no evidence of widespread arterial disease).

This hospital is within easy reach of the London Hospital, where there is a renal transplant team on call 24 hours a day, who have a mobile unit fully equipped for the preservation of kidneys.—I am, etc.,

M. W. SALAH

St. Margaret's Hospital,
Epping

Syphilis as a Cause of Backache

SIR,—I should like to report an uncommon presenting symptom of secondary syphilis.

A 25-year-old labourer attended a casualty department in the small hours of the morning complaining of persistent low backache of recent onset. Subsequent examinations by an orthopaedic surgeon and rheumatologist failed to make a diagnosis, but by this time, two weeks after initial presentation, the backache had ceased, a generalized eruption having developed. The patient was seen by a dermatologist, who, suspecting secondary syphilis, referred the patient to this department.

At this stage, three weeks after first attendance, the patient manifested several of the more common symptoms and signs of secondary syphilis: sore throat and malaise; a widespread maculo-papular, squamous, erythematous eruption on the trunk

and flexor surfaces of the arms; palmar and plantar syphilides; a squamous eruption on the scrotum; syphilitic balanitis; anal condylomata lata; snail track ulcers on the tonsils; and a generalized lymphadenopathy.

Treponema pallidum was demonstrated from the anal condylomata lata. Reiter protein complement fixation test; cardiolipin Wasserman reaction, and fluorescent treponemal antibody test were positive. Venereal Disease Reference Laboratory slide test was positive with serum diluted 1 in 64. Erythrocyte sedimentation rate was 50 mm in the first hour.

The patient admitted to a previous episode of urethral gonorrhoea and recent frequent promiscuous homosexual liaisons, usually after meeting men while drinking in public houses in the locality. He completely recovered after treatment with 13.5 megaunits intramuscular procaine penicillin given over 15 days, a Jarisch-Herxheimer reaction being sustained after the first injection of penicillin.

Stokes *et al.*¹ gave the term ostealgia to the indefinitely localized bone pains of secondary syphilis for which no pathological background could be found. They stated that traditionally the leading symptomatic feature of the bone changes of early and recurrent syphilis was pain, nocturnal in character, exaggerated by heat, and relieved by movement of the affected part. Other authorities, such as Catterall,² state that osteoscopic pains, characteristically worse at night, may occur in secondary syphilis—however, usually in the long bones and due to a periostitis.

In recent years the incidence of early syphilis has declined to such an extent that its more unusual manifestations are not often seen. Nevertheless as Jefferis³ has stated, two or three cases of this potentially crippling and sometimes fatal disease are still seen each week in the larger metropolitan clinics. For the reason that syphilis may still be the great imitator this case is reported.

I should like to thank Dr. J. L. Fluker for his encouragement for me to report this case in his care.—I am, etc.,

MICHAEL WAUGH

West London Hospital,
Charing Cross Group of Hospitals

¹ Stokes, J. H., Beerman, H., and Ingraham, N. R., *Modern Clinical Syphilology*, 3rd edn. Philadelphia and London, Saunders, 1944.

² Catterall, R. D., *A Short Textbook of Venereology*. London, English Universities Press, 1965.

³ Jefferis, F. J. G., *British Medical Journal*, 1970, 3, 225.

Sickle-cell and Altitude

SIR,—We were gratified by the interest in our paper on "The Sickle-cell and Altitude" (4 December, p. 593) and would like to thank the four correspondents from Ghana (1 January, p. 53; 8 January, p. 113; and 15 January, p. 177).

We would agree that the sickle-cell trait is more widespread than in specifically Negro races and, in retrospect, we regret the omission from our paper of a statement on its geographical distribution. Our critics have interpreted this omission as ignorance on our part, but we would suggest that this fact is so well established that at the time we considered such a statement to be unnecessary. It is true that two small surveys in the Lake Copais and Petromagoula areas of Greece revealed sickle-cell