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Correspondents are urged to write briefly so that readers may be offered as wide a selection of letters as possible. So many are now being received that the omission of some is inevitable. Letters should be signed personally by all their authors. A selection of letters as possible. So many are now being received that the omission

Motor Insurance and Ischaemic Heart Disease

SIR,—When a patient had a myocardial infarct recently this year he was advised to inform his large and well-known motor insurance company and received the following reply:

"We . . . note that you have recently suffered a coronary. In the circumstances it will be necessary for you to obtain, at your own expense, a report from your doctor regarding your general state of health and physical condition. The report should make particular reference to the coronary, the period of disability it caused, and the prognosis."

"Would you kindly inform us of any restrictions which the coronary has imposed on your activities, and your present blood pressure readings. If you have ever suffered from any other diseases, would you please advise us of the details."

"Finally, would you please request your doctor to incorporate into his report the following wording: 'I certify that I have today examined . . . who in my opinion is suffering from no physical or mental disability which would of itself, and regardless of any other consideration, make it undesirable for him to drive a motor vehicle on the public highway.'"

I have discussed this letter with my medical colleagues and with a representative of the insurance firm, and have also sought the opinion of the North West Regional Health Authority's legal adviser, and it seems that various questions warrant further discussion, including the following.

(1) The awareness of doctors and the general public that insurance companies expect to be informed of any change in health which would affect ability to drive.

(2) The advice given to patients recovering from illness.

(3) The professional time required to prepare and interpret detailed reports of the nature requested.

(4) Whether such reports should be issued by general practitioners or hospital doctors, and if the former the amount of information contained in hospital discharge letters. Insurers hope that a

hospital doctor would pass on any relevant information to a G.P.

(5) Should insurance companies seek to impose a higher standard of fitness than is statutorily required of drivers (after all, insurance companies have to show a profit)? Most insurance policies extend beyond the statutory insurance requirements and it is basically in respect of this that the risk is underwritten.

(6) Restrictions on activity at, say, two months may not be applicable 12 months after infarction. Insurance companies accept this point but are interested in the current state of health.

(7) Have insurance companies a right to know about all illnesses, physical and psychiatric, likely to affect ability to drive? How should they obtain such information? What is the position of the insured if he does not, for whatever reason, supply such information?

(8) Would a shortened certificate of ability to drive be acceptable by the insurance companies? Is express verbal consent by a doctor sufficient? The companies would prefer such information to be given in writing.

(9) Refusal to continue an insured person's policy might prevent him from returning to his employment, a step which insurers would be reluctant to take.

This letter is written with the knowledge of all parties concerned in the hope that it will lead to further discussions between the medical and insurance professions.—I am, etc.,

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Cervical Epithelial Dysplasia

SIR,—With the likelihood of an increase in the prevalence rate of squamous carcinoma of the cervix in the next decade¹ there is an urgent need for a simple, reliable method of assessing the neoplastic potential of its pro-

posed precursor states of dysplasia and in situ carcinoma. There can be few more soul-searching problems in clinical gynaecology today than the management of the increasing number of young women with these lesions. Traditional histopathology is unlikely to provide an answer—indeed, the opposite applies as the plethora of descriptive terminology confirms. Immunological and genetic methods of surveillance probably represent the best hope for the future.

But until these methods are perfected it would be dangerous and potentially lethal to regard dysplasia as a purely benign condition. This is unfortunately the impression that some readers may acquire after reading your leading article (8 February, p. 294). The overwhelming and objectively determined scientific data convincingly confirm the potentially malign nature of many dysplastic and in situ carcinoma lesions.^{2,3} The Los Angeles figures of Stern⁴ that show the hundred-fold increase in the risk of developing invasive carcinoma in women already known to have dysplasia should be proof enough.

It is therefore surprising that you should emphasize the rather negative aspects of the Baltimore studies,^{5,6} which regard dysplasia as a "non-specific inflammatory reaction." This study on a 97% white private practice population, a rather unusual group in the American experience in which to find these lesions, found differences in the amount of vaginal discharge, in the titres of various antibodies, and in the presence of *Trichomonas vaginalis* between dysplastic and in situ carcinoma groups. The presence of the latter organism was determined retrospectively when "any mention of trichomonas was noted"⁵ in Papanicolaou-stained preparations of cervical and vaginal material obtained by the self-administered vaginal irrigation technique. The assessment of these rather subjective and variable parameters, plus the fairly liberal histological interpretation of in situ carcinoma as you suggest, added to by the neglect to standard-

ize the age at first coitus when assessing behavioural differences between the groups⁷ must make one very careful about extrapolating and allowing their conclusions to affect in any way the current British practice of dealing with dysplasia.

From the recent preliminary results⁸ of a study of a high-risk population for the development of cervical malignancy evidence would tend to suggest that a proportion of the dysplastic lesions discovered are reflections of current sexual behaviour rather than of present vaginal "infections." The prevalence rate of the mild and moderate dysplastic lesions occurring in a subgroup of 148 unemployed young women (mean age 18 years), many of whom were known drug addicts and vagrants and who were leading a highly promiscuous sexual existence, was 75 per 1000. Inflammatory infiltration within the epithelium and stroma was predominantly by monocytes, lymphocytes, and plasma cells.⁹ This reaction was more common in the first few years after starting coitus. Prostitutes within this population, as well as having a high rate of these minor dysplastic lesions (64 per 1000), had a high rate of severe dysplasia (86 per 1000). It may be that the minor (mild and moderate) and major (severe) stages of dysplasia represent a semiquantitative measure of short- and long-term patterns of sexual promiscuity. The continuation of this type of behaviour by the unemployed girl may lead in time to the development of the more severe type of dysplastic lesion.⁹

One could speculate that the intensity of the inflammatory infiltrate could represent an immune type of rejection mechanism initiated in the early life history of these disorders. This may well provide a basis for the well-known regression of the minor dysplastic lesions.¹⁰ Inability of this mechanism or a similar one operating in relation to pregnancy and delivery⁸ to destroy this tissue must invariably leave it with a malignant potential.³ Unfortunately differentiation of the benign or malignant nature of each one is not possible. Certainly they need treatment and close observation.—I am, etc.,

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¹ Beral, V., *Lancet*, 1974, 1, 1037.

² Coppleson, M., and Reid, B., *Preclinical Carcinoma of the Cervix Uteri*, p. 146. Oxford, Pergamon Press, 1967.

³ Richart, R. M., in *Pathology Annual* 1973, vol. 8, ed. S. C. Sommers. New York, Appleton-Century-Crofts, 1973.

⁴ Stern, E., *Obstetrical and Gynecological Survey*, 1969, 24, 711.

⁵ Thomas, D. B., *American Journal of Epidemiology*, 1973, 98, 10.

⁶ Thomas, D. B., and Anderson, R. I., *American Journal of Epidemiology*, 1974, 100, 113.

⁷ Singer, A., *Lancet*, 1974, 2, 41.

⁸ Singer, A., *British Journal of Obstetrics and Gynaecology*, 1975, 82, 81.

⁹ Singer, A., *The Cervix Uteri of Women in Prison*, D.Phil. thesis, University of Oxford, 1973.

¹⁰ Reagan, J. W., on *Dysplasia, Carcinoma in situ and Microinvasive Carcinoma of the Cervix Uteri*, ed. L. Gray, p. 294. Springfield, Thomas, 1964.

Trasylol for Pancreatitis

SIR,—I recently (21 September 1974, p. 741) described two patients with acute pancreatitis complicated by a consumptive coagulopathy in whom treatment with aprotinin (Trasylol) coincided with a marked deterioration in

pulmonary function which improved remarkably when the infusion was stopped. I suggested that aprotinin, a potent fibrinolytic inhibitor, may have permitted the build-up of fibrin deposits within the microcirculation of the lung.

Dr. G. L. Haberland (23 November, p. 469), implies that the properties of aprotinin were not fully considered when assessing its effect in our patients. The process of intravascular coagulation is certainly highly complex and involves the activation of many proteases other than plasminogen, including those in the kallikrein-kinin and complement systems. Aprotinin, a broad-spectrum protease inhibitor, may indeed have significant effects in addition to those on the fibrinolytic mechanism. However, the evidence for a beneficial effect of this material in disseminated intravascular coagulation referred to by Dr. Haberland is derived mainly from animal experiments where the fibrinolytic response may differ considerably from that in man. I am sure I am not alone in my view that it is the intravascular deposition of fibrin which is primarily responsible for the failure of organ perfusion and the haemorrhagic manifestations which are basic to this pathological process in man. It follows that, except in very rare circumstances, the normal fibrinolytic response can be only beneficial and should, if anything, be enhanced rather than suppressed.

I feel strongly, therefore, that the experience with our two patients cannot be dismissed so lightly and that until the properties of aprotinin are more clearly defined this substance should be used with extreme caution where acute pancreatitis is complicated by evidence of intravascular coagulation.—I am, etc.,

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Classification of Non-Hodgkin Lymphomas

SIR,—Professor G. Hamilton Fairley and Dr. J. E. Freeman (28 December, p. 761) state that "the precise histological type" of lymphoma is important in predicting prognosis "which in turn has a bearing on the type of treatment to be used."

The authors present a "simple classification on which treatment is based." Though this classification might work in many cases for the reasons intended, it also might lead to considerable confusion; in addition, the classification is certainly not precise. I wish to present an alternative classification of non-Hodgkin's lymphomas (see table) on which treatment may be based. I believe this is not more difficult than the one presented by Professor Fairley and Dr. Freeman, yet it corresponds more closely to that used by most pathologists and may reduce the amount of confusion.

Group 1	Follicular (nodular), poorly differentiated lymphocytic
	Well differentiated lymphocytic (chronic lymphocytic leukaemia)
Group 2	Diffuse, poorly differentiated lymphocytic
	Diffuse and follicular histiocytic

Most pathologists today classify non-Hodgkin's lymphomas on the basis of both cytological features and histological pattern as either follicular (nodular) or diffuse.¹ A lymphoma with a follicular histological pattern generally is associated with a better

prognosis than the same lymphoma with a diffuse pattern. In our experience and the experience of others² most of the follicular lymphomas are those of the poorly differentiated lymphocytic type (about 50% of these cases at the time of the initial lymph-node biopsy are follicular), and the follicular pattern is associated with a considerably better prognosis and a longer period of survival than the diffuse type of the poorly differentiated lymphocytic lymphoma. Into which group would one place a follicular lymphoma (group 1 of Fairley and Freeman's classification) of the poorly differentiated type (group 2)? There also appears to be a difference in length of survival between patients with follicular and diffuse types of histiocytic lymphoma, though both histological types of this lymphoma appear to be considerably more aggressive than the lymphocytic types. The histiocytic lymphomas, therefore, should remain in group 2.

The well differentiated lymphocytic lymphoma, in our experience, is almost always diffuse and is always also leukaemic, being called chronic lymphocytic leukaemia when diagnosed in blood and bone marrow. The enlarged lymph nodes in chronic lymphocytic leukaemia represent the infiltration by the well-differentiated or mature-appearing lymphocytes. The disease is therefore usually widespread, but nevertheless is usually associated with a relatively good prognosis.—I am, etc.,

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¹ Gall, E. A., and Rappaport, H., in *Seminars on Diseases of the Lymph Nodes and Spleen*, ed. J. R. McDonald. Chicago, American Society of Clinical Pathologists, 1958.

² Jones, S. E., et al., *Cancer*, 1973, 31, 806.

Needs and Resources

SIR,—In your leading article "Lean Times Ahead for N.H.S. Finances" (8 February, p. 297) you refer to the extra responsibilities imposed on the N.H.S. as a result of reorganization; there are other extra responsibilities. The fall in the birth rate during the past 10 years and estimates of the size and age composition of the population during the remaining 25 years of this century suggest that the load on the N.H.S. will continue to increase while the numbers in the age groups from which nurses and paramedical staff are recruited will diminish. These trends, indeed, make sense of the slower projected growth rate in education which you mention.

The number of births in England and Wales has fallen from 867 000 in the year to mid-1965 to 653 000 by mid-1974; that means that last year there were 214 000 less births than occurred in the year nine years previously. Inevitably this means a rise in the proportion of elderly people in the population. But equally important is the continuing rise in the number of persons aged 75 years or more until the end of this century (the birth rate did not fall below 20 live births per 1000 persons living until 1924-5). The education service can be trimmed to anticipate expected changes in school entry numbers five years in advance. It is more difficult to make the correct adjustments to the allocation of resources to the N.H.S. and the personal social services