ize the age at first coitus when assessing behavioural differences between the groups[7] 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 results[8] 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 delivery[8] to destroy this tissue must invariably leave it with a malignant potential.[3] Unfortunately differentiation of the benign or malign nature of each one is not possible. Certainly they need treatment and close observation.—I am, etc.,

A. SINGER

University Department of Obstetrics and Gynaecology,
Jessop Hospital for Women,
Sheffield

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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 kallekrein-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.,

M. L. LEWIS

King's College Hospital,
London S.E.5

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 others[2] 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.,

BERTRAM SCHNITZER

Department of Pathology,
University of Michigan Medical Center,
Ann Arbor, Michigan

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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