It was thought that the positive Wassermann reaction was probably a false biological result related to the increased protein in the cerebrospinal fluid, and a further cerebrospinal fluid specimen obtained four weeks later was completely normal with a negative Wassermann reaction.

Of the seven cases reported, apart from Case 5, a burnt-out tabes, and Case 7, a juvenile neurosyphilis, I would hesitate to attribute the symptoms to a syphilitic infection of the central nervous system unless the C.S.F. T.P.I. test was positive, and apparently this test was not performed in all the cases reported. Furthermore, even if the T.P.I. test is positive it is well to remember that syphilis can involve the central nervous system asymptotically. The suggestion that the "Wassermann reaction today is of even greater importance than in the past" deserves some qualification. It is well known that many diseases and conditions other than syphilis can produce positive Wassermann reactions, and if this test is relied on alone to diagnose syphilis many patients will be treated unnecessarily for this disease, and, perhaps more important, the true diagnosis may be delayed.

A 46-year-old married woman, under investigation for bilateral pleural effusion, was referred in October 1967 because serological tests performed on a specimen of her blood showed the following results: venereal disease reference laboratory, positive 1:4; Wassermann reaction, positive; Reiter test, negative. There was no historical or clinical evidence of syphilis, and a negative *Treponema pallidum* immobilization test from a further specimen of blood sent for examination confirmed that the positive Wassermann reaction and V.D.R.L. tests were due to false biological reactions.

Many V.D. clinics nowadays, when investigating difficult diagnostic cases, use the V.D.R.L., W.R., and Reiter tests as a screening procedure, and then confirm or refute the diagnosis of syphilis on the result of the T.P.I. and/or fluorescent treponemal antibody test.—I am, etc.,

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Sunderland.

BASIL LEVY.

Oral Contraceptives and Thromboembolic Disease

SIR,—The articles by Drs. W. H. W. Inman and M. P. Vessey, and M. P. Vessey and Richard Doll (27 April, pp. 193 and 199) concerning the increased incidence of venous thrombosis and embolism in women seem to indicate that oral contraceptives are more dangerous than other forms of contraception and should not be prescribed unless absolutely necessary.

However, it has been my impression that the incidence of carcinoma of the uterine cervix is much less in those women who have been taking an oral contraceptive. I think that it might be of considerable interest to compare statistics of carcinoma of the cervix in these same groups of women to see if their overall incidence of significant disease (vascular and cancer) might actually have been lower than expected, because there was far less cancer in this group.—I am, etc.,

JOHN P. CANBY.

Consulate General of the United
States of America,
Melbourne, Australia.

Smoking, Sputum, and Lung Cancer

SIR,—It has been pointed out to me that a difference in the prevalence of lung cancer between those reporting and those not reporting persistent respiratory symptoms (23 March, p. 732) might be attributable substantially to differences of age distribution. This is because respiratory symptoms might be expected to be reported more frequently by older individuals among whom the prevalence of lung cancer is greater.

In preparing the data for publication the available age range had been divided into those aged 40 to 59 years and those aged 60 years and over, and an examination of this division seems to indicate that the differences in prevalence of lung cancer between those with and those without chronic sputum production were too great to be accounted for by

differences in age. However, the data have been re-examined, using a finer (quinquennial) age distribution, and age-standardized prevalences have been calculated for those with and for those without chronic sputum production within each smoking category.

The Table shows actual and age-standardized prevalences of lung cancer, as well as the ratio between the rate for those with and the rate for those without chronic sputum production, both for the actual prevalence rates and the standardized prevalence rates. It will be seen that, although standardization has reduced the extremely high ratio of the prevalences in those with and those without chronic sputum among the ex-smokers and pipe smokers, the reduction in the ratios among the cigarette smokers is

trivial, and in one consumption category the ratio is in fact increased.

The conclusion, therefore, would seem to be that any differences in prevalences of lung cancer between those with and those without chronic sputum production is substantially due to differences other than age.—I am, etc.,

J. RIMINGTON.

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Stockport, Cheshire.

Record Sales of Cigarettes

SIR,—I am encouraged by Dr. E. H. L. Harries (2 March, p. 576) and by the publication of two recent reports to comment further on the subject of smoking.

On 22 February the *Daily Telegraph* reported: "Record sales in Britain last year of 119,100 million cigarettes." A week later came the report: "British fire losses reach new peak—£90,000,000—10% higher than in 1966." (*Times of Malta*, 29 February).

It is apparent from the first report that the findings of top scientists of the Medical Research Council, checked repeatedly and independently, that cigarette-smoking is highly carcinogenic and responsible for a great many other morbid states, have been, for all practical purposes, thrown on the scrap-heap. Can it be doubted, moreover, that the astronomical number of naked lights and smouldering cigarette butts which derive from smoking are mainly responsible for the figure in the second report?

And, unless I am utterly wrong in my basic thinking, we of the medical profession are 100% responsible for this appalling state of affairs, because tobacco-smoking is a disease, a drug addiction, which, like opium smoking, is wholly preventable, and it is our sole function to eliminate disease.—I am, etc.,

Marsascala,
Malta.

LENNOX JOHNSTON.

Recurrent Tetanus

SIR,—The extreme rarity of tetanus recurring or relapsing was stressed by Mr. S. Y. D. C. Wickramasinghe and Dr. Malinie Fernando (2 December 1967, p. 530), and rightly so. This prompts me to report a case from my records.

A 20-year-old male was admitted to the hospital at Calicut, India, in September 1963 with an unmistakable clinical picture of tetanus. A chronic ulcer near the left ankle was thought to be the route of infection. *Clostridium tetani* was demonstrated in a swab taken from the ulcer.

Rates of Lung Cancer per 1,000 Males aged 40 years or more

	Non-smokers		Cigarette Smokers								Ex-smokers		Pipe Smokers		All Subjects	
			1-9		10-19		20 +		All							
	NS	S	NS	S	NS	S	NS	S	NS	S	NS	S	NS	S	NS	S
Actual rates ..	0	0	0.73	6.25	0.91	4.96	1.87	5.01	1.30	5.09	0.24	10.13	0.97	13.76	0.84	6.29
Age-standardized rates	0	0	0.64	4.63	0.90	5.81	2.67	4.66	1.73	5.96	0.53	9.26	1.77	12.82	1.31	7.84
Ratio $\frac{(S)}{(NS)}$ actual rates ..			8.333		5.451		2.679		3.915		42.208		14.186		7.488	
Ratio $\frac{(S)}{(NS)}$ standardized rates			7.198		6.418		1.743		3.441		17.468		7.231		5.971	

S denotes volunteers claiming daily sputum for a minimum of 5 years and NS denotes those not claiming this symptom.