was systematically covered largely accounts for the fall now occurring in the number of cases of cervical cancer in Aberdeen. In the interests of economy, and in the light of our knowledge of the high-risk groups, should the taking of smears not become part of all routine antenatal care? The majority of cases would then be detected before the high-risk patient had finished childbearing. Twenty years later a fall in the incidence of the disease could be predicted, a fall which will never happen if only the well women offering themselves for screening and rescreening are covered.

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Psychological sequelae of therapeutic abortion

SIR,—While I agree with the general tone of your leading article on this subject (22 May, p 1239), your statement that "comparisons between those aborted and those refused have shown little difference" needs clarification. The studies you quote in fact show quite serious sequelae in those refused, even though these are presumably subjects thought sufficiently healthy to be able to cope with their pregnancy. Combining the figures of Pare and Raven,[1] Clark *et al*,[2] and Hamill and Ingram,[3] 285 out of the sample of 597 were refused termination. Of those refused, 103 aborted (36%) and only 115 finally kept their baby (40%). Of 73 women who continued their pregnancy, Pare and Raven found that at follow-up 34% still regretted that termination had not been performed, while Clark *et al* found that 7 out of 93 women who had been refused termination were mentally worse at follow-up compared with only one out of 111 whose pregnancy had been terminated.

It should be borne in mind that these figures are likely to under-estimate morbidity, since those who dropped out of follow-up are likely to have been the more unstable and these were almost entirely in the refusal group. Thus it is important that fear of psychological as opposed to physical sequelae should not restrict referral for abortion on psychological grounds.

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[1] Pare, C M B, and Raven, H, *Lancet*, 1970, **1**, 635.
[2] Clark, M, *et al*, *Lancet*, 1968, **2**, 501.
[3] Hamill, E, and Ingram, I M, *British Medical Journal*, 1974, **1**, 229.

Effects of legal termination on subsequent pregnancy

SIR,—Mr J A Richardson and Professor G Dixon (29 May, p 1303) state that some patients referred to them from pregnancy advisory centres ask that their general practitioners should not be informed of their referral. They believe that "it seems reasonable to assume that these patients will not admit their termination during a future pregnancy."

As medical officers in the pregnancy advisory service from which these patients will have been referred we would like to make three points. (1) A patient's request that her GP should not be informed is infrequent and is not acceded to lightly. (2) All patients are told the risks of termination to subsequent pregnancies and if it is agreed that the GP is not to be informed the importance of telling a subsequent obstetrician is stressed. (3) Patients who request that their GP should not be informed about termination sometimes make the request not because they wish to withhold the information from their doctor but because they fear that the information will become available to secretaries and receptionists.

We feel that there is no evidence that these patients will withhold the information from an obstetrician during a subsequent planned pregnancy.

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Flupenthixol for depression

SIR,—The letters from Drs J M Kellett and J P R Young (5 June, p 1405) highlighted fundamental differences in the models of depressive illness that are in current use.

I suggest that the presence or absence of "biological symptoms" in a patient complaining of depression is only one of many factors to be considered when making the diagnosis. Many patients with clearcut manic and depressive episodes, which make the diagnosis beyond reasonable doubt, do not show the biological disturbances of the classic syndrome of endogenous depression. In addition, many patients who are "dissatisfied with life" have "biological" complaints such as loss of libido or appetite.

Like Dr Kellett, I would like to know if flupenthixol is a useful alternative to amitriptyline for those patients who make a specific response to tricyclic antidepressants.

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Methysergide ineffective in spasticity

SIR,—Recent observations[1 2] have suggested that L-5-hydroxytryptamine (5-HT) is a neurotransmitter in man. It seemed possible that spasticity could be due to pathological over-activity in neuronal systems using 5-HT as a transmitter. Since methysergide is a 5-HT antagonist a small open trial was conducted to assess whether this drug would reduce spasticity.

Informed consent was obtained from a small number of patients suffering from spasticity in the legs, due to various pathological processes, which had not responded to therapy with conventional agents. Spasticity was assessed by clinical examination at the knee joint and of gait. (In view of the negative results in this pilot study plans to measure spasticity quantitatively were abandoned.) Methysergide was given orally in an arbitrary dosage of 1 mg thrice daily for three weeks. No patient was taking other drugs known to affect tone during this period. The patients had been selected carefully to ensure that there had been a fairly constant degree of spasticity for several months before the trial. This was therefore an uncontrolled trial.

The results are shown in the accompanying table. It can be seen that methysergide in the oral dosage used here had no significant effect on spasticity and did not benefit the patients. No side effects were encountered. Methysergide is therefore no substitute for the drugs currently available for the treatment of spasticity. One has to admit that this was a very small trial and that there was a rather varied pathology present. In view of the negative findings it would seem unlikely that the spasticity was due to an over-active 5-HT system, although this conclusion is certainly open to doubt.

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[1] Lhermitte, F, Marteau, R, and Degos, C F, *Revue Neurologique*, 1972, **126**, 107.
[2] Van Woert, M H, and Vimalah, S, *Neurology*, 1975, **25**, 135.

Homoeopathy

SIR,—Your issue of 15 May (p 1217) contained a review of Dr Margery Blackie's recent book, *The Patient, Not the Cure*.

The reviewer, trained presumably as an objective scientist, states: "The book makes it quite clear what rubbish homoeopathy is intellectually." This observation is made without any apparent clinical knowledge or experience of the discipline and so is surely a complete denial of objectivity. How can the reviewer explain away the physical benefits for patients in the five hospitals in Britain where homoeopathy is practised and the availability of its materia medica on prescription from general practitioners using homoeopathy within the NHS?

The increasing interest among veterinary colleagues is apparent in their membership of the Faculty of Homoeopathy. Farmers are very practical people; when their sick animals are improved and cured (as does happen) by homoeopathy, would your reviewer explain this to the farmer as being due to some charisma of the veterinary practitioner over the animal—or some mystical means of preparation of the medicine?

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Oral lesions in tuberculosis

SIR,—I read with interest the case report by Mr P G McAndrew and others (29 May, p 1320) and would like to emphasise a number of points.

Although it is now a much less common disease in Britain, patients are still presenting with tuberculosis in late stages.[1] The lesions are now less easily recognised as they can mimic

Patient	Age (yrs)	Diagnosis	Features	Result of therapy
1	59	Multiple sclerosis	Spastic paraparesis	Doubtful benefit
2	53	" "	" "	No change
3	71	Cervical spondylosis	" "	No change
4	32	Jamaican neuropathy	" "	No change
5	69	Cervical spondylosis	" "	No change
6	67	Cerebrovascular disease	Left hemiparesis	No change