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Repeated Acupuncture and Serum Hepatitis

SIR,—The letter by Dr. K. K. Hussain (6 July, p. 41) suggesting a possible link between repeated acupuncture and serum hepatitis is of considerable interest in view of the situation in China. On a recent visit to the People's Republic of China, under the auspices of the British Council, we saw the widespread use of acupuncture as a therapeutic measure, particularly in the commune hospitals. We even saw it being practised by children, on each other, in a class where acupuncture was being taught. The needles were placed in a sterilizing fluid but there was no evidence that any other form of sterilization was used.

We also noted the high incidence of hepatocellular carcinoma, and were told that one-third of these patients had a classical history of previous hepatitis and that the

liver usually showed cirrhosis at the time of diagnosis of the hepatic carcinoma. A sequence of events is suggested: virus hepatitis is extremely common, some patients proceed to develop cirrhosis, and some of these go on to develop primary liver tumours. The interest lies in how the virus is disseminated, and superficially it seemed to us that acupuncture could easily be responsible for this.—We are, etc.,

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Smoking and Deep Vein Thrombosis

SIR,—The observation that venous thromboembolism is more likely to occur in hospital patients admitted for the treatment of myocardial infarction if they were non-smokers on admission than if they were smokers who then stopped smoking, which was reported by Dr. A. J. Handley and Mr. D. Teather and by Drs. P. Marks and P. A. Emerson (27 July, p. 230 and 232 respectively), is of considerable interest. At first sight the difference appears surprising, but it accords with a number of similar observations in other comparable circumstances. Avery Jones, Pygott, and I,¹ for example, found that gastric ulcers healed less well in non-smokers than in smokers who stopped smoking (61% average healing in four weeks against 83%), and Badaracco and Vessey² found that women admitted to hospital with "idiopathic" venous thromboembolism who had not been taking oral contraceptives were more likely to relapse than women who had been taking them but subsequently stopped

(36% within three years compared with 8%). Finally, we may note that smoking does not appear to be a cause of venous thrombosis.³

These results agree, therefore, in indicating that patients who have a probable cause for their disease fare better, once that cause has been removed, than patients whose condition has no such removable cause. Dr. Handley and his colleagues suggest that among those who develop myocardial infarction non-smokers tend to be intrinsically more susceptible to both arterial and venous thrombosis. In the light of the above observations their suggestion seems attractive.—I am, etc.,

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¹ Doll, R., Jones, F. A., and Pygott, F., *Lancet*, 1958, **1**, 657.

² Badaracco, M. A., and Vessey, M. P., *British Medical Journal*, 1974, **1**, 215.

³ Vessey, M. P., and Doll, R., *British Medical Journal*, 1969, **2**, 651.

Endometriosis and Pseudopregnancy

SIR,—I think your leading article, "Endometriosis and Pseudopregnancy" (29 June, p. 682) underestimated the usefulness of hormone therapy. Andrews and Larsen,¹ whom you quote, treated only one-seventh of their patients by pseudopregnancy alone. Though in the much larger group treated by surgery alone results in terms of subsequent pregnancy were better than in the small group treated only with hormones they do not clearly indicate the reasons for their choice of treatment, and this selection pattern may have had a considerable effect on the results.

In a small personal series of 77 cases reported in 1969² there were 20 women who desired pregnancy: 14 of them became pregnant, some of them twice, after infertility which in three cases had been present for eight, nine, and 11 years respectively. The percentage success in this admittedly small group was materially higher than that quoted by Andrews and Larsen for their patients treated surgically. Subsequent surgery has so far been necessary in only two of the 77 cases in our series. One of these was a woman aged 23 with an extensive endometriosis of the uterosacral area causing dyspareunia so severe that she had to abandon intercourse. After treatment with norethisterone acetate and ethinyl oestradiol for nine months the mass in the pouch of Douglas was greatly diminished and her pain disappeared. She became pregnant and was delivered of a healthy child. A year later her pelvic mass and her dyspareunia recurred. Once again pseudopregnancy for 12 months was followed by such improvement that a second pregnancy occurred and was successfully concluded. She remained symptom free for a further year, but required hysterectomy at the age of 30 because severe symptoms reappeared. I am confident that conservative surgery in this patient would have been valueless and that a primary surgical approach would have deprived her of all hope of having children. We have not shared Page's³ experience that conservative therapy for endometriosis may be followed by prolonged anovulation. All the pregnancies in our series occurred within six months of the completion of treatment.

Even if, as Andrews and Larsen found, the need for subsequent operation is not