structural damage to the temporal bone, and that the underlying mechanism is clearly understood.

The literature on the skull pathology in Paget's deafness is admirable and full of instances of careful, meticulous work.²⁻⁵ Devoted as it is, however, to instances of widespread skull involvement it is forced to speculate on possible mechanisms for the deafness. The issue therefore remains in doubt, which is why we regret our lack of foresight regarding impedance audiometry and the unavailability of temporal bone tomography. From the viewpoint of advancement of knowledge it would seem more valuable to study minimal lesions than to concentrate on the distortive and destructive end-stage result.

Our patient improved with calcitonin therapy and recent audiometric examination shows further improvement in respect of voice perception. At his age (73 years) and with his degree of crippling deafness it is unlikely that this improvement could have been achieved had there not been some, as yet undefined, link between that deafness and Paget's disease of bone.—I am, etc.,

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1 Moffatt, W. H., Morrow, J. D., and Simpson, N., *British Medical Journal*, 1974, 4, 203.

2 Anson, J. B., and Wilson, J. G., *Archives of Otolaryngology*, 1937, 25, 560.

3 Clemis, J. D., et al., *Annals of Otolaryngology and Laryngology*, 1967, 76, 611.

4 Tamari, M., *Annals of Otolaryngology and Laryngology*, 1942, 51, 170.

5 Henkin, R. I., Lifschitz, M. D., and Larson, A. L., *American Journal of the Medical Sciences*, 1972, 263, 383.

Society's Responsibility

SIR,—We, the undersigned, also clinicians practising general psychiatry from a peripheral hospital, fully endorse all Dr. B. W. Durrant's observations (21 June, p. 683). It is to be hoped that the social self-deceptions and euphemisms of the 1960s, which were also reflected in some mental health policies, will now yield to a return to the reality being forced upon society by the increasingly colder realism of the present period.—We are, etc.,

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Hormonal Pregnancy Tests and Congenital Malformations

SIR,—While I accept the possibility of teratogenic effects as a result of the use of hormones for the diagnosis of pregnancy (leading article, 30 November 1974, p. 485) and the valuable comments by Dr. Isabel Gal (28 June, p. 749), it is surely wrong to emphasize these drugs to the exclusion of many others. The pharmaceutical industry markets a multitude of drugs that should be avoided during pregnancy and especially the first trimester. Yet how many practitioners consider that patients taking these preparations should also be advised against pregnancy? The danger of a pregnancy occurring

while currently on drug therapy, which would normally have been avoided if the patient was already known to be pregnant, should not be forgotten. Is there a case for advising patients against a pregnancy during the course of treatment which the manufacturers have stated should be avoided during pregnancy or must this come as a result of litigation for negligence?

It is now standard radiological practice to x-ray female patients in the first half of the cycle lest an early pregnancy be inadvertently irradiated. While the concept of refusing dangerous drugs for non-emergency conditions to patients who cannot provide proof of adequate contraception would be unacceptable, the consequences of indiscriminate prescribing without offering contraceptive advice may be equally unacceptable to the patient.—I am, etc.,

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Sexual Life after Hysterectomy

SIR,—Mr. A. G. Amias (14 June, p. 608) has usefully stressed some ways of avoiding precipitating sexual difficulties after hysterectomy. "Newspaper medicine" arouses some anxieties, but does try to answer questions that over-hasty consultations leave unanswered.

Hysterectomy is still seen by women as an operation in which "everything is taken away," including the patient's femininity and sexuality. Psychologically it is a mutilation. It will alter the way she sees herself and possibly the way her husband sees her. Pronouncement of the need for hysterectomy induces psychological shock in most women, and this will be succeeded by feelings of deprivation and resentment unless adequate time is given to a full discussion of exactly what the operation is for, why no alternative is feasible, what it will involve in pain, disability, and time, and what her health, appearance, and sexual feelings will be like later. She should be asked her anxieties and given truthful answers. A further discussion after the sense of shock has eased is often helpful.

If her personal history has been unrewarding it should be anticipated that hysterectomy will precipitate breakdown, and careful evaluation of the absolute need for hysterectomy should be made. If there is no alternative on medical grounds, then skilled psychotherapeutic support should be obtained and continued after the operation.

It is my impression that a good deal of distress could be avoided if attention could be given to these points.—I am, etc.,

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Epidemiology of Disappearing Diseases

SIR,—Poliomyelitis provides one example of the modern problem of epidemiological surveillance of a formerly epidemic infection which has almost disappeared as a result of effective control measures. Reduced awareness of this now unfamiliar disease may not only encourage neglect of the immunization that is essential for continued control of

poliomyelitis but can also decrease the accuracy and speed of clinical recognition of cases. Notifications could then give a falsely optimistic impression of the degree of control of the disease. Virological data from diagnostic laboratories will not reveal the true situation unless clinical suspicions have caused specimens to be sent to the laboratories.

During the five years 1970-4 11 cases of paralytic poliomyelitis were detected in Scotland. Polioviruses were isolated from three incompletely or unvaccinated adults, two type 1 and one type 2—the last being vaccine-recipient-associated. From the other eight no virus was isolated because faecal specimens were submitted too late or not at all—in one case not until an orthopaedic surgeon was consulted about weak and wasted thumb muscles. Serological tests were too late to detect diagnostic rising antibody titres, but unusually high titres suggested recent poliomyelitis in all. Provisional diagnosis had included multiple sclerosis, neurological complication of rubella vaccination, and various other neurological and psychiatric disorders. The patients diagnosed serologically included four children (three preschool) and four adults. One illness started in Majorca and one shortly after return from Spain, both involving adults—a reminder that immunity to poliomyelitis may be as important as that to typhoid for visitors to our usual warm, sunny vacation resorts.—We are, etc.,

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Duodenal Obstruction due to Abdominal Aortic Aneurysm

SIR,—We noted with interest the recent report of a case of duodenal obstruction due to abdominal aortic aneurysm by Mr. H. M. Adair (28 June, p. 727). We should like to report a case of oesophageal obstruction due to a thoracic aortic aneurysm.

An 85-year-old woman presented with a three-week history of dysphagia and recurrent vomiting. On examination she appeared emaciated and grossly dehydrated. A chest x-ray film suggested the presence of a dilated and calcified aorta. A barium swallow showed a dilated oesophagus with a smooth termination and complete obstruction at the gastro-oesophageal junction with virtually no barium seen beyond this point. Oesophagoscopy confirmed the narrowing of the oesophagus, but no mucosal lesion was present and the instrument passed easily into the stomach, which was normal. Unfortunately, the patient's condition deteriorated and she died before further investigation and treatment could be undertaken. At necropsy the proximal two-thirds of the oesophagus was dilated and the distal third was compressed by the descending thoracic aorta. No intrinsic oesophageal lesions were present. Both the thoracic and abdominal parts of the aorta were dilated, measuring up to 6 cm in maximum diameter, and histological section confirmed the atheromatous nature of the large aortic aneurysm.

Aneurysmal dilatation of the thoracic aorta is an uncommon cause of dysphagia because the oesophagus is readily displaced to the right.¹ Radiological studies showing displacement of the oesophagus by a dilated aorta