with very subjective "morality". Most of *CMAJ*'s readers probably found Dr. Sullivan's letter eccentric, perhaps even amusingly so. With AIDS an established reality, however, there is no place for diversions from the challenge of solving the mystery and reducing human suffering. The effort required to refute Dr. Sullivan, while a vital necessity, is indeed a tedious diversion.

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The suggestion that homosexuality is an addiction is incredible; we know too much about sexuality to take it seriously.

If Dr. Sullivan chooses to believe all media reports about homosexuals, why shouldn't the general public believe everything the media say about physicians (e.g., they are arrogant, insensitive, filthy rich and dangerous to one's health)?

The frequency of sexual activity claimed by homosexuals I have met has ranged from something bordering on compulsiveness to complete celibacy — the same spectrum of activity found in heterosexuals.

Dr. Sullivan's assertion that homosexuals act out sexually "in reckless disregard for the effect on personal, family, social and work life" must be judged in two ways. First, he cites no evidence that homosexuals act this way any more than do heterosexuals. But surely he is aware of the broken homes, abuse, venereal disease and other social ills caused by such "perfectly understandable" events as the lust of an ageing manager for his 22-year-old secretary. Second, the worst social consequences of homosexuality (e.g., blackmail) are possible mainly because of society's condemnation of homosexuality.

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Aplasia cutis congenita and methimazole

We read with interest the recent article on aplasia cutis congenita, by Drs. Julius Martin and J. Barrie Ross (*Can Med Assoc J* 1984; 130: 421–422). The pathogenesis of this disorder remains speculative.[1] However, five published cases as well as five verbally reported cases of aplasia cutis congenita have occurred in infants whose mothers had been treated with methimazole during pregnancy.[2,3] Because of this association propylthiouracil may be the preferred drug for the management of thyrotoxicosis in pregnant women.

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Therapeutic window for amitriptyline analgesia

A window is an opening in a wall designed to admit light and fresh air. Dr. C.P.N. Watson's use of the term "therapeutic window" in discussing the analgesic effect of amitriptyline (*Can Med Assoc J* 1984; 130: 105) is eye-catching but does not throw any light on the subject of drug doses and levels. A "therapeutic window" is apparently nothing more than a range of drug doses or levels of a drug in the blood at which a certain effect occurs.

All physicians would serve their readers better by substituting crisp and accurate language for arcane phrases, such as "therapeutic window", that may be confusing and add nothing to the reader's understanding.

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Abortion denied — outcome of mothers and babies

Apparently Dr. Carlos Del Campo (*Can Med Assoc J* 1984; 130: 361, 362, 366) consulted only a small portion of the literature in concluding that it shows "no evidence that a continued unwanted pregnancy will endanger the mother's mental health". He ignored the Aberdeen study,[1] whose authors examined the psychosocial characteristics of over 300 women applying for abortion; 60% of the abortions were approved. Fifteen months later the authors re-examined the women using the same battery of tests as well as a psychiatric interview. One of the findings at follow-up was that one in nine of the unmarried women who had had an abortion was depressed, compared with one in four of those who had continued the pregnancy, an effect that approached the 5% level of significance. The authors concluded: "Thus in the context of Aberdeen, at this particular period, the practice of abortion to solve the problems of the woman with an unwanted pregnancy was not specifically associated with a high degree of later social and psychological difficulties. On balance, the outcome was apparently more beneficial to the women concerned than the outcome of those who continued the pregnancy." The latter group of women did not simply "continue the pregnancy": they were forced to continue the pregnancy by being denied a legal abortion, presumably because they were too healthy to qualify for abortion under British law as interpreted by the gynecologist to whom they were referred.

In addition, Dr. Del Campo was very selective in examining the work done in Czechoslovakia. Matejcek and colleagues[2] examined 220 women who had been refused an abortion twice for the same pregnancy. These mothers were compared with a group of mothers who were matched for education and socioeconomic background and who had accepted their pregnancy. In spite of an apparently changed attitude toward the offspring, the women who were victims of manda-

For prescribing information see page 1388 →