

Latent Morbidity after Abortion

SIR,—Therapeutic abortion is now one of the operations most commonly performed in the U.K., and it is right that the short-term and long-term hazards should be fully explored. Unfortunately, the report by Margaret and Arthur Wynn, of which you write so eulogistically in your leading article (3 March, p. 506), presents no new data, and its only true contribution is polemical.

Dr. D. M. Potts (24 March, p. 739) has already shown that the interpretation by the Wynns of the risks of subsequent ectopic pregnancy, low-birth-weight babies, and congenital malformations were erroneous. Similarly Mr. A. D. R. Ogborn (14 April, p. 114) points out that the Wynns have misquoted and misunderstood the findings of the 1958 British Perinatal Mortality Survey. Unfortunately, both these criticisms apply equally to your leading article.

The Wynns have published a report whose skeleton is a selected collection of excerpts from the medical literature clothed with the flesh of emotive argument. This is a justifiable activity in the politics of persuasion, but your uncritical leading article gives it the implied authority of the medical establishment, and this is exactly how it has been interpreted in the national press. Since notification began in 1968 nearly half a million women have obtained abortions in this country, and large numbers of them have become unnecessarily alarmed by the unfortunate publicity given to this biased publication. It is because we are seeing such patients that we write this letter.—We are, etc.,

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SIR,—The Karman catheter technique is constantly described as “non-traumatic,” as the cervix need not be dilated (Dr. A. Hordern, 12 May, p. 368). Two reports published do not support this. In the report from King's College Hospital¹ it is stated that “in some nulliparae with a pinhole os it was necessary to dilate the cervix up to 7 mm.” It is regrettable the number is not specified. The report continues: “The practice of exploring the uterus with a small Friedman curette . . . was found to be invaluable for ensuring that the cavity of the uterus was empty,” yet five of the 17 patients immediately or subsequently admitted to hospital had retained parts and three acute pelvic sepsis. These figures from a total of only 127 patients give no grounds for complacency and the authors quite rightly mention that “the real anxiety . . . [is] infertility.”

The authors of the Yugoslav report on 322 cases² concludes that “the catheter . . . was not suitable for terminating pregnancies beyond the sixth week.” The 12% incidence of retained products at six weeks is not satisfactory. Dilatation was necessary in 15 cases, despite the fact that 203 of the women

were multigravidae. As a “sound” was introduced to overcome the resistant cervical os towards the end of the series it is difficult to assess the total figures for dilatation. This report also mentions the disadvantage of the flexible catheter with a retroflexed uterus or “eccentrically” placed ovum.³ In view of these reports it is disconcerting that the Karman method is being “advertised” to schoolchildren, students, etc. as “the new non-traumatic American technique.”—I am, etc.,

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¹ Lewis, S. C., Lal, S., Branch, B., and Beard, R. W., *British Medical Journal*, 1971, 4, 606.

² Beric, B. M., Kupresanin, M., and Hullah, J. F., *American Journal of Obstetrics and Gynecology*, 1972, 114, 273.

³ Wynn, M., and Wynn, A., *Sane Consequences of Induced Abortion to Children Born Subsequently*. London, Foundation for Education and Research in Childbearing, 1972.

Herpes Simplex Virus Type 2 in Acute Aseptic Meningitis

SIR,—It is well known that herpes simplex virus (H.S.V.) can cause involvement of the central nervous system (C.N.S.) varying from benign aseptic meningitis to severe encephalitis. In a Washington study,¹ covering a 25-year period and comprising 49 cases of H.S.V. infection of the C.N.S., encephalitis running a severe course and with a mortality of 70% was observed in 36 cases, benign meningitis in 10, and an atypical illness, of which C.N.S. manifestations were but a part, in three cases. In a Stockholm study of 3,117 cases of acute aseptic infections of the C.N.S.,² covering a 10-year period and including 17 cases of H.S.V. infection, severe encephalitis was observed in three cases and aseptic meningitis in 14, 10 of the latter patients being between 15 and 29 years old.

H.S.V. has often been isolated from brain tissue, type 1 being mostly identified in children and adults and type 2 in the newborn.^{3,4} H.S.V. has been isolated from cerebrospinal fluid (C.S.F.) in only a few cases.² In 1971 Terni *et al.*⁵ reported on three men with genital H.S.V. infections who fell ill with signs of meningitis 5-10 days after the appearance of genital vesicles. H.S.V. type 2 was recovered from vesicular fluid but not from C.S.F. specimens. Recently Craig and Nahmias³ isolated H.S.V. type 2 from the buffy coat in two cases of meningitis.

In the discussion of the Stockholm study² the hypothesis was proposed that one type of H.S.V. can cause encephalitis and another type meningitis. This hypothesis is supported by the report presented here of seven patients treated at the Roslagstull Hospital, Stockholm, for acute aseptic meningitis from whose C.S.F. specimens H.S.V. was isolated (S.W.). All seven C.S.F. strains were identified as H.S.V. type 2 by immunoelectro-osmophoresis with type-specific rabbit immune sera (S.J.).⁶

The patients, six females and one male, were between 16 and 26 years old. Six of them had a benign meningitis with fever lasting 2-3 days and rapidly disappearing symptoms. One patient had fever for seven days and persistent headache, lability, dysphoria, long-continued asthenic symptoms, and a disability period totalling 10 months. None of them had vesicles in or around the mouth, but two had noticed

vesicular lesions in the genital region for the first time. These appeared about one week before the onset of meningeal symptoms with fever, headache, and neck stiffness. In one of these two patients a maculopapular rash developed over the face and neck simultaneously with the meningeal symptoms. Two patients had sharp muscle pain in the legs for a few days before the onset of the meningeal symptoms.

In all cases the C.S.F. showed a pleocytosis of 100-700 leucocytes/mm³, usually at least 300/mm³. Almost all the leucocytes were mononuclears, except in one case in which 68% were mononuclears. The total protein content of the C.S.F. varied between 50 and 222 mg/100 ml; in three cases it exceeded 110 mg/100 ml. H.S.V. type 2 was isolated from C.S.F. specimens taken 1-5 days after the onset of meningeal symptoms. All patients had significant rises in serum titre of complement-fixing antibodies against H.S.V. antigen.

Electroencephalograms were normal in five cases and slightly or moderately, and transiently, pathological (slow basic rhythm and non-specific slow dysfunction) in two.

Five to seven months after the onset two patients developed very benign aseptic meningitis, diagnosed clinically and on the basis of C.S.F. findings. Attempts to isolate virus from C.S.F. specimens were unsuccessful and no other aetiological agent was found.

The clinical picture of H.S.V. type 2 meningitis in our seven patients differed completely from that of herpes encephalitis. For example, during the same period a 38-year-old man with high fever and deeply unconscious was treated at the hospital. After nine days' illness he died from haemorrhagic encephalitis. H.S.V. type 1 was isolated from brain tissue taken postmortem. The age distribution of the seven patients was in accordance with that of patients with genital herpes attending a venereal disease clinic.^{7,8}—We are, etc.,

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¹ Olson, L. C., Beuscher, E. L., Artenstein, M. S., and Parkman, P. D., *New England Journal of Medicine*, 1967, 277, 1271.

² Sköldenberg, B., *Scandinavian Journal of Infectious Diseases*, 1972, Suppl. 3.

³ Craig, C. P., and Nahmias, A. J., *Journal of Infectious Diseases*, 1973, 127, 365.

⁴ Juel-Jensen, B. E., and MacCallum, F. O., *Herpes Simplex, Varicella and Zoster. Clinical Manifestations and Treatment*. London, Heinemann, 1972.

⁵ Terni, M., Caccialanza, P., Cassai, E., and Kieff, E., *New England Journal of Medicine*, 1971, 285, 503.

⁶ Jeansson, S., *Applied Microbiology*, 1972, 24, 1, 96.

⁷ Nahmias, A. J., Joey, W. E., Naib, Z. M., Luce, C. F., and Duffey, A., *American Journal of Epidemiology*, 1970, 91, 539.

⁸ Rawls, W. E., Tompkins, W. A. F., and Melnick, J. L., *American Journal of Epidemiology*, 1969, 89, 547.

Malaria Risk to Travellers

SIR,—Professor B. G. Macgrath's recent letter (21 April, p. 175) concerning malaria risk to travellers is, like all his previous communications on this subject, timely and to the point.

During the past year I have gone into travel agents at random whenever I have had a few moments to spare and have asked, in every case: “I'm thinking of visiting