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Correspondence

Correspondents are asked to be brief.

Cat Leukaemia

SIR,—Recent revival of interest in the question of whether leukaemia can be transmitted from animals (21 March, p. 755) has served as a reminder that the first phase of the Oxford survey of childhood cancers included a question on household pets. That is to say, the mothers of children who had recently died from leukaemia or other malignant diseases (cases) were asked if the family kept hens or household pets, and the same question was asked of control mothers, or mothers of children who had sex, date of birth, postal district in common with the cases but were otherwise picked at random from local birth registers.

	Leukaemias		Other Cancers		Total
	Cases	Matched Controls	Cases	Matched Controls	
Cats	91	79	78	100	348
Dogs	67	66	80	63	276
Birds	33	48	44	53	178
Rabbits	20	15	23	22	80
Hens	33	36	36	32	137
Any of the above	149	148	159	171	627
None of the above	94	95	98	86	373
All Households	243	243	257	257	1,000

The answers received from 1,000 mothers are given in the accompanying Table, which shows that there was no difference between the cases and controls.—I am, etc.,

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Spinal Cord Compression

SIR,—Mr. Bernard Harries (7 March, p. 611, and 14 March, p. 673) is to be congratulated on a lucid exposition of the complex subject of cord compression.

Not every hospital is within easy range of a neurosurgical centre, and not every neurosurgical service can at once accept every patient whom, under ideal conditions, it would be wise to refer. A good deal of spinal surgery will still need to be done in non-specialized units. This is particularly true of patients wtih paraplegia due to extradural metastases.

The fatal character of the primary disease should not lead the doctor into an attitude of despair. The patient must ultimately die, but there is no reason for him to die with the miseries and indignities of an irreversible paraplegia—incontinent, helpless, and with progressive bed sores. Rapid diagnosis, rapid surgical decompression (even at the hands of such neurosurgical amateurs as orthopaedic surgeons), and energetic aftercare: these are the desiderata which may enable, say, half those admitted to hospital with paraplegia due to metastases to return home. They will die, but with little spinal pain, without distressing complications, and without demoralization.—I am, etc.,

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SIR,—In his excellent articles on spinal cord compression, Mr. Bernard Harries gives one view which must be seriously challenged—namely, that no effective drugs are available to reduce spasms and spasticity in the paraplegic, except morphine and its substitutes in liberal doses (14 March, p. 673).

I have recently listed some of the published evidence of the remarkable efficacy of diazepam (Valium) as a spasmolytic, and have reported the rapid relief of painful spasm from an injection of the drug.[1] Furthermore, the period of freedom from spasticity after intramuscular diazepam may be used to start procedures which might not otherwise be possible—for example, active movements of the limbs, prone lying, and straightening the legs so that calipers can be fitted and the patient got on his feet. Diazepam may also be used by mouth,[2] and persistence with such regimens of drug and drill involving weight-bearing results in a gradual resolution of paraplegic spasticity.

Given due care, diazepam is safe to use, but it is wise to start parenteral treatment with 5 mg. intramuscularly (particularly in the case of brain-stem lesions and in debilitated and elderly patients) and to increase on subsequent days to a dose which gives relief of spasticity without untoward side-effects—the main ones being drowsiness, and aggravation of weakness and ataxia in some neurological disorders. Tolerance to diazepam develops and patients on the oral drug require bigger parenteral doses.[1]

Paraplegia in flexion should be regarded as a preventable tragedy, and, given effective treatment from the outset, neurectomies and tenotomies should rarely be necessary.—I am, etc.,

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REFERENCES
1 Wilson, L. A., *Gerontologia Clinica* 1970, **12**, 168.
2 Wilson, L. A., and McKechnie, A. A., *Scottish Medical Journal*, 1966, **11**, 46.

Surgical Treatment of Thyrotoxicosis

SIR,—I read with interest the article by Dr. A. J. Hedley and others on the results of surgical treatment of thyrotoxicosis (28 February, p. 519). While the figure for hypothyroidism appears to be a high one, I must agree wholeheartedly in regard to the