IDIOPATHIC VENOUS THROMBOSIS IN R.C.G.P. ORAL CONTRACEPTION STUDY — REVISED CALCULATIONS

I.C.D. category	*Takers*		*Ex-Takers*	
	Observed number	*Standardised rate (TWY)†*	*Observed number*	*Standardised rate (TWY)†*
Superficial thrombosis of leg	64	1.89	12	1.03
Deep thrombosis of leg	33	0.98	5	0.41
Other and unspecified sites of thrombosis	10	0.29	1	0.08
Periods of observation	32,850 women years		11,763 women years	
I.C.D. category	*Controls*		*Ratio of rates*	
	Observed number	*Standardised rate (TWY)†*	*Takers/ Controls*	*Ex-takers/ Controls*
Superficial thrombosis of leg	29	0.72	2.63*	1.42
Deep thrombosis of leg	7	0.17	5.62*	2.37
Other and unspecified sites of thrombosis	6	0.16	1.82	0.49
Periods of observation	41,170 women years			

* $p < 0.01$

† TWY = thousand women years

the following month. The tabulated data represent the first attack of venous thrombosis in women with no known predisposing cause. The experience of these women subsequent to their first attack is also excluded.

The adjusted observations are simultaneously standardised for ages, parity, cigarette smoking, and social class, to the combined adjusted experience of Takers, Ex-Takers, and Controls, using the indirect method.

The revised estimate of the risk of an association between oral contraceptive usage and venous thrombosis is similar to the approximation published in our report. The estimated attributable risk of 117 (98) per 100,000 Pill users per year for superficial thrombosis and 81 (91) per 100,000 for deep thrombosis shows little change. The numbers in brackets indicate our former estimates. The increased rate in Ex-takers could easily have occurred by chance.

The new calculations have no bearing on the issue as to whether the reported observations were biased. Our conclusion that bias did not make an important contribution to the observed differences has been discussed elsewhere.[1-3]

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REFERENCES

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2 Kay, C. R. (1974). Oral contraceptives and health: Thromboembolic Disease. *Lancet*, **2**, 1138–1139.
3 Kay, C. R. (1974). Oral contraceptives and health. *Lancet*, **2**, 514–515.

ADVERTISEMENTS IN MEDICAL JOURNALS

Sir,

The Department of Health and Social Security has requested members of the pharmaceutical industry to reduce their promotional expenditure from 13·8 per cent to ten per cent of turnover. The industry has a well-founded and creditable reputation for giving support to educational activities, including the indirect support of reputable and valuable medical journals by the placing of advertisements. Naturally each company will wish to decide for itself where economies are to be made, but I plead that they be selective and bear in mind the advantage to the whole profession of continuing to advertise in journals of true educational value.

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GENERAL-PRACTITIONER OBSTETRICIAN

Sir,

Elstein and his colleagues are to be congratulated on their portrayal of the evolution of the general-practitioner obstetrician in the next decade (May

Journal). If general-practice obstetrics is to survive then it must be in a form similar to that which they describe. There is one minor point, however, with which I would like to disagree. They state that patients booked for general-practitioner care should after delivery be nursed in a group of beds set apart from the consultant beds. I would suspect that it is better for these beds to be fully integrated. Certainly such a system works extremely well in the general-practitioner beds in the Queen Mother's Hospital Glasgow, which are fully integrated with the consultant beds.

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REFERENCE

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SOCIAL CLASS AND MORBIDITY/ MORTALITY

Sir,

I read with great interest (April *Journal*) that the Manchester Research Unit of the Royal College of General Practitioners responsible for the Oral Contraception Study is setting up a joint study with the Royal College of Obstetricians and Gynaecologists on the consequences of induced abortion. Such a study would be of great importance.

However, one aspect of the report *Oral Contraceptives and Health* which has been of great concern to me, is the under-representation of working-class women (which is not mentioned in the report). Social classes 4 and 5 form 17·4 per cent of Takers and 19·7 per cent of Controls. The 1970 census showed that social classes 4 and 5 form 27 per cent of women aged 15–44. Social class 3 women were equally represented in Takers and Controls (42·6 per cent) but are in fact 53·32 per cent of the female population in the reproductive years.

Since the Registrar General's 1961 occupational mortality tables show that women in social classes 4 and 5 already have a much higher mortality rate than middle-class women apart from the possible serious side-effects of the Pill—and the difference is particularly noticeable in certain groups, e.g. miners' wives—I cannot help wondering whether they are at greater additional risk as takers of oral contraceptives.

I have tried, but failed, to trace any studies of social class differences in mortality and morbidity among women on the Pill.

The social class composition of the sample is, presumably, because working-class patients are under-represented in the lists of those doctors who took part in the oral contraception study.

One can well imagine how such a bias might affect conclusions about the consequences of abortion.

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PARTICIPATION BY PATIENTS IN PRIMARY CARE

Sir,

When, in July 1973, the Aberdare Health Centre was opened it was considered that the patients (10,000) should be encouraged to become involved in running their general-practitioner services.

It was decided that this could best be done by calling a general meeting open to all patients from which a patients' committee would be elected and also to have lectures on the theme *Look after your Health*. At the first general meeting a committee of eight patients was formed. At the second general meeting this was increased to 13. The chairman is a retired teacher, the secretary a young industrial worker. One of the members is also a member of the local Community Health Council.

The Patients' Committee now meets (with the practice health team, doctors and nurses) every five or six weeks—in future the liaison social worker, will also attend. Initially the Committee discussed immediate difficulties, the doctors' weekend rota arrangements, the surgery appointments system, parking facilities, redecoration, the provision of picture rails, the health education programme.

Now, however, we have worked out how to provide a new limited screening for the over 60s to whom letters, signed by the senior doctor and the secretary of the patients' committee, are being sent soon after their 60th birthdays.

At a recent meeting the main matters discussed were, the waiting time for barium meal x-rays, the open university, training of doctors, the James White Abortion (Amendment) Bill, the health education programme for the next session, and euthanasia.

There has been a public lecture on *The Open University and Doctors*, but not yet on abortion or euthanasia.

The Community Health Council is now helping the Patients' Committee in pressing for improvements in the special x-rays service and the local abortion services.

One of the doctors reported at a recent Committee meeting that he had had difficulty in getting a violent mentally ill patient into hospital at a holiday weekend. It was decided, after discussion, to ask a psychiatrist to give an open lecture on *The Care of the Mentally Ill at home and in Hospital*, so that difficulties of this nature can be discussed in an amicable way.

I think, that patients should be encouraged to attend the Patients' Committee meetings to give their opinions, advice or complaints. There should also be more frequent general meetings for the same purpose.