Correspondence

Letters to the Editor should not exceed 500 words.

Oral Contraceptives

SIR,—At a time when the Dunlop Committte on Safety of Drugs has just reported on the contraceptive pill and has, albeit with reservations, put a "safe" level on it, I for one am feeling more and more uneasy about prescribing it. The excellent paper by Drs. E. R. Bickerstaff and J. MacDonald Holmes (25 March, p. 726) prompts me to report a case of my own.

The patient, a woman of 29, a married State-registered nurse with two children, was supplied with a popular brand of the "pill" in October 1966. She attended again in December 1966 complaining of headache, dizziness, and faintness after having taken only "a few of the pills." She wished to try another brand. She had had a similar attack three years previously when she had been given hormones to help her conceive. I should add here that both the previous prescriptions had been supplied by different doctors.

I had heard similar complaints from other patients during their first month on the "pill," none of which had come to anything, and in any case this patient had complained of "dizzy spells" in the past when not taking the "pill." I therefore prescribed another contraceptive pill, one with which I was more familiar and which has a lower oestrogen content than the first. I saw her one month later for evaluation. She had been well, and I therefore gave her a prescription to last six months.

Her husband attended surgery on 3 April 1967, one week after I had read the paper by Drs. Bickerstaff and Holmes, and mentioned that his wife had had further dizzy spells. I therefore obtained a full history from her which I now state in chronological order.

In May 1963 her doctor gave her hormone tablets (? nature) to help her conceive. After two weeks' treatment she fainted, was aphasic and completely blind for two days, and had a severe frontal headache. (Her mother has migraines and the patient herself has had occasional severe frontal headaches.) Haemoglobin was found to be very low, and she was given intramuscular injections of Imferon (iron dextran) and the hormone tablets were stopped. She was completely well after one week, and in fact began to improve immediately the tablets were stopped. She conceived three months later.

In October 1966 she was supplied with a course of contraceptive pills. On the tenth day she fainted three times, became dysarthric, and then completely aphasic. She had blurring of vision, numbness and loss of power in the right hand and arm, severe frontal headache, and sharp stabbing pain in the occipital region. She took two codeine tablets and went to bed. She had a little blurring of vision the next morning which passed off and then she was quite well. She had withdrawal bleeding on the eleventh day. Haemoglobin at this time unknown, but three months earlier it was 13.5 g./100 ml.

In December 1966 she was supplied with a different contraceptive pill by myself; this she had been taking for three months without any trouble. On Easter Sunday (26 March) she felt dizzy and faint; numbness and loss of power developed in her right hand and arm; she became dysarthritic; and then aphasic. She had a severe frontal headache and sharp stabbing occipital pain which occurred at about half-hourly intervals. She stopped the "pill" and was well by the next day.

This patient was obviously suffering from cerebral arterial insufficiency, and as far as I am concerned there seems little doubt that all the attacks were due to the administration of hormones. I have advised her never again to take the "pill."

At the time of writing I have not the advantage of having read the official report on the "pill" made by the Committee on Safety of Drugs (see 8 April, p. 68). I make my comments only on what I have gleaned from the Press. We are told that women on the "pill" are only running a risk equal to that of a pregnant woman (less risk if one includes the act of childbirth itself and the puerperium). Pregnancy is certainly a natural state of affairs—but one lasting, say, 20 years?

I do not know in what proportion iatrogenesis has increased with the increase in number and complexity of drugs now available to us. I do know that without such reports as that by Drs. Bickerstaff and MacDonald Holmes to guide us the proportion would be greater and we in the front line of medicine and our patients would be very poorly placed. One of my clinical teachers used to say (and I quote): "When I go to bed at night I ask myself, 'Have I done anybody any good today?', and then 'Have I done anybody any harm?', and if I have done neither I have not done too badly." His statement did not mean quite so much to me then as it does now. It goes without saying that a committee such as that headed by Sir Derrick Dunlop is absolutely essential, but often as in this case the committee finally leaves it up to the individual practitioner.

I shall continue to prescribe the "pill." All other things being equal, and in the light of the findings I do not believe I have the right to withhold it from my patients. I shall certainly take more care to whom I prescribe it.—I am, etc.,

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Post-transfusion Hepatitis

SIR,—Dr. A. J. Salsbury (25 March, p. 756) has drawn attention to the value of a plasma protein solution as a transfusion fluid which is free of the risk of transmitting hepatitis from donor to recipient. Until, and even when, this material is more generally available, greater use should be made of plasma substitutes, such as dextran or dextran 110, both of which are safe and effective plasma volume expanders when limited in total volume in cases of blood loss to not more than 1,000 ml. Besides being free of the risk of transmitting hepatitis, dextran solutions have the advantage that they are less expensive than plasma protein solution, plasma, or whole blood, as well as being more readily available.

A recent experience suggests that not all cases of post-transfusion hepatitis are being reported to directors of Regional Transfusion Services. Following a recent report in this region of a patient who had developed hepatitis following a transfusion of plasma, it was found that plasma from the same batch had been given to four other patients of whom three had become jaundiced (which had not been reported). In one of these the doctor had considertd the diagnosis, but had decided that the patient was "too mildly affected to be suffering a post-transfusion hepatitis." Because of the delay in the detection of this infected plasma many of the donors whose plasma was included in this pool have been bled again. The recipients of their blood are under follow-up observation to determine whether any will show evidence of hepatitis. It would clearly have been far more desirable to have detected the carrier donor(s) sooner than inadvertently to have exposed other recipients to the risk of acquiring hepatitis.

May I offer a reminder through your columns that whenever a patient is found to be suffering from hepatitis he should be asked whether he has received a transfusion of blood or blood products during the preceding six months, and that if this is so the possibility that his may be a case of post-transfusion hepatitis must be reported without delay to the director of the appropriate Regional Transfusion Service?—I am, etc.,

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Malaria, Glucose-6-phosphate Dehydrogenase Deficiency, and Hb S

SIR,—Attention has been drawn in your columns recently (25 February, p. 496, and 7 January, p. 49) to the incidence of malaria in Great Britain. It has been pointed out that in any patient presenting with unexplained fever who has recently returned from the tropics the differential diagnosis of malaria must be borne in mind.

Without minimizing the importance of this observation, I should like to draw attention to a related problem which, because of the numbers of people involved, may eventually prove to be of greater importance in this country. There are now in our midst people who previously lived for generations in areas that are endemic for malaria. These ethnic groups show a high frequency of glucose-6-phosphate dehydrogenase (G-6-PD) deficiency and/or of Hb S—both being genetic traits capable of presenting certain syndromes in themselves. As the immigrant population continues to rise, the problem imposed by these phenomena will require increasing attention. West Indians or Asians living in Britain are unlikely to consult their doctor on account of malaria, but in any condition for which they seek treatment the possibility