prophylactic regimen (which entails peroperative intermittent calf compression only) should produce a reduction in the incidence of postoperative deep vein thrombosis of 82%, while the regimen used by Mr. Hills and his colleagues (which covers the preoperative, peroperative, and postoperative periods) should produce an overall reduction of only 60%.

Direct comparison between the two trials is difficult, but Mr. Hills's comments on the effects of malignancy prompted us to reexamine our figures. In our admittedly small series, intermittent calf compression did produce a significant reduction in the incidence of postoperative D.V.T. in patients with and without malignant disease (see Table).

	No D.V.T.	D.V.T.	Total	Incidence
Evidence of Malignancy = 8				
Control ..	6	2	8	25%
Treated ..	8	0	8	0%
Non-malignant = 31				
Control ..	21	10	31	32·2%
Treated ..	29	2	31	6·4%

This apparent difference may, we feel, be explained by a study which we recently conducted into haemodynamic effects of the compression device used by Mr. Hills and his colleagues. In a series of four patients we assessed the haemodynamic effects of this device using the procedure that we had used in our previous investigation.[2] Our results[3] revealed that because the device uses a much slower compression rate than our own, its effects on flow are less dramatic. We would suggest that we were able to achieve a greater reduction in the incidence of postoperative thrombi because our device has a far more pronounced effect on the haemodynamics of the situation. For example, whereas Mr. Hills's device can increase the peak femoral vein flow by 75%, our's is capable of increasing it by 700%.

We are, however, well aware of the limitations of our comparatively small clinical trial, and are currently engaged in a much larger trial in order to test our hypothesis.—We are, etc.,

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SIR,—May I be permitted to comment on the paper on the prevention of deep leg thrombosis by intermittent compression of the calf, by Mr. N. H. Hills and others (15 January, p. 131)? I submit that the good results obtained by this compression are in harmony with my contention that deep leg thrombosis often stems from pressure on the external iliac veins by unnatural accumulations in the colon in westernized societies. Any colonic accumulations pressing on the iliac veins must act as an impediment to the natural blood flow, and if the present intermittent compression of the calf lessens the incidence of leg thrombosis so, I submit, must careful attention to the colonic contents do this too.

Pulmonary embolism has been shown[1] not only to have increased generally in European countries and even in the United States since the turn of the century, but also to have particularly done so in Britain since 1952. Not only is this great increase compatible, after allowing for a latent period and possibly also a threshold value, with the increasing consumption of refined carbohydrates, especially sugar, but there is also a special feature in Britain that appears relevant. A decline, or even open abandonment, of some aperient and enema routines both in operation cases and in medical-bed patients during the above decade has been observed. Careful inquiries of quite a number of surgeons have deepened the above impression and also shown that there may have been some substitution of suppositories for the larger measures mentioned, with consequent less effect on any colonic loading present.

Over and above all this is the rarity of deep thrombosis and other venous conditions in tribal Africans living on unrefined carbohydrates, but not in their cousins the negroes in the United States living on our type of refined diet, all of which I have myself laboured hard to bring to light.[2] There is also the 3:1 preponderance of clinical deep leg thrombosis in the left leg, established in many references.[3] I cannot accept that left-sided preponderance of deep leg thrombosis arises from the crossing of the right common iliac artery over the left common iliac vein "as the main aetiological factor" in the production of the thrombosis.[4] Apart from throwing no light on the even greater preponderance of varicocele on the left side, such an explanation would appear incompatible with evolutionary principles, and it would not explain the virtual absence of the condition in tribal Africans.

I hope the authors of the present paper may incorporate the help provided by these arguments in their present approach.—I am, etc.,

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Domiciliary Family Planning Service

SIR,—In his comments on Dr. Elizabeth Wilson's report (18 December, p. 731) on the Domiciliary Family Planning Service in Glasgow Dr. James A. McGarry (29 January, p. 315) appears to have failed to appreciate that the "poverty, unemployment, overcrowding, alcoholism, debt. and disease" in the families to which Dr. Wilson refers are usually the direct result of the low intelligence of both marriage partners. I work in a very similar service in Liverpool where we have identical problems to Glasgow. Patients requiring long-term domiciliary care for contraception are often illiterate and sharing a bed with two or three children; either circumstance makes it virtually impossible for them to use a thermometer and chart to identify their infertile period. While applauding the excellent work done by the Catholic Marriage Advisory Council in Liverpool, so far as I know they do not visit patients at home to give advice, and it is unrealistic to expect a mother of 10 or 12 children to make time to visit the clinic, even if she knows where it is and has the bus fare to get there.

Like Dr. Wilson, in my home visits I offer only contraception, but other social agencies are invariably concerned with these problem families, and are usually offering help and support by the time my help is requested. Saving money for the community is merely incidental to the service, which aims primarily at improving the quality of family life by limiting the number of children in accordance with the wishes of the parents.

Lastly, I should like to take this opportunity of expressing my gratitude to the vast majority of my general practitioner colleagues of all denominations in Liverpool, who have readily given permission for me to visit their patients under this scheme, and have often provided extremely helpful background information.—I am, etc.,

BERYL EVANS

Liverpool 18

SIR,—I was most interested in Dr. Elizabeth Wilson's account of the Glasgow Domiciliary Family Planning Service (18 December, p. 731). I work as the domiciliary family planning doctor in the London Borough of Haringey (population 240,000). Our domiciliary service has been functioning since 1968 and has had over 500 referrals with a carrying case load of more than 300. (Birmingham and London Borough of Wandsworth have each had over 1,000 referrals.)

My experiences with the domiciliary service bear out Dr. Wilson's findings. This is an effective (though relatively costly) way of providing family planning advice for socially inadequate families. However, there are some further points that need to be mentioned.

The success of the domiciliary service depends on the referring agents. Some health visitors and social workers are reluctant to discuss contraception with the families they visit. From my experience, the reason for this is inadequate training in this field so that they are unable to discuss contraception and sexual problems without embarrassment.

The reasons why some couples do not use contraception are complex: it is not just fecklessness. The reasons may lie in the methods themselves. Some couples find the cap messy to use; the sheath interferes with the spontaneity of the sex act; the newspaper reports of deaths on the pill have done much harm in creating unnecessary anxiety in just those couples least able to evaluate the risks associated with taking the pill. The I.U.D. often results in heavier periods which poorly motivated women refuse to tolerate. Some families find it difficult to plan ahead and just live from day to day, unwanted pregnancies being part of the general chaos of their lives. There also exists a small and (from the family planning point of view) difficult group of families in which having babies appears to be their *raison d'être*.

It follows from this that the relationship of trust and confidence between doctor, nurse, and patient is most important. Time