a variety of drugs was often required, preparations of thiazides with enteric-coated potassium chloride are the one common factor. Indeed all 36 patients in a series reported from Stockholm[3] were taking these drugs. Animal experiments indicate that potassium chloride is the offending substance, possibly because of the speed with which it is released from enteric-coated tablets,[4] and that it acts either directly on the mucosa or via the submucosal blood-vessels. However, it is as well to bear in mind the recent suggestion[5 6] that thiazides may sometimes cause vasculitis of the skin and kidneys. Ulceration of the small bowel may represent a hypersensitivity reaction similar to that provoked by aspirin. Consequently it would be wise to warn patients taking thiazide-and-potassium preparations to report any gastro-intestinal symptoms. There are several objections to the use of such combinations, and where potassium is needed it is best given separately in an effervescent form. Moreover, the need for long-term medication with thiazide and potassium in the individual patient should be constantly reviewed. The greatest danger from potassium depletion is in patients with chronic heart failure and cirrhosis of the liver, and for them diuretics other than the thiazides may be preferable.

Teen-age Pregnancy

The birth rate is rising almost everywhere. In England and Wales in the years 1961, 1962, and 1963 the total births were 817,271, 844,265, and 858,884, and for these years the number of mothers under the age of 20 when the babies were born was 60,465, 67,986, and 72,250, respectively. Thus about 8% of all births are to women in the teen-age group. Very nearly 22% of births in these young women are illegitimate, compared with an illegitimacy rate of about 5.5% in women aged 20 and over. But it should be recognized that the age at marriage of spinsters is falling, and that of teen-agers bearing children about four-fifths will be married.[1-3] Hence it would seem that the social response to earlier sexual maturity, as demonstrated by the falling age of the menarche,[4] is earlier marriage.

Of those who marry under the age of 20 about 68% will have borne a child before the marriage is one year old.[1 2] The problems that may arise are both social and obstetric. H. M. Wallace[5] has analysed these two aspects of teen-age pregnancy in the United States of America, and mentions the effects of early marriage on the further education of women, the higher divorce rates of those who marry young, the high fertility of teen-agers, and the obstetric troubles that occur in them. Teen-agers constitute a high-risk group of mothers and are especially apt to develop complications—such as excessive gain of weight, prolonged labour in those under the age of 14, a high caesarean section rate in those aged 12 and 13, a high rate of pre-eclamptic toxaemia and of cervical laceration, and a higher rate than average of perinatal and neonatal deaths and of prematurity. The young teen-age girl who is pregnant presents an increased risk to both herself and her child.

These American findings were not fully borne out by the study of the adolescent primigravida made in Britain by R. H. Stearn.[6] Though his series of thirty patients was small, they were all under the age of 16 and so might have been expected to pin-point some of the major obstetric difficulties apt to be encountered. Stearn found that there was a high incidence of hypertension and toxaemia (8 out of the 30). The foetal head was not engaged before labour in over half of the girls; induction of labour was not needed at all and neither was caesarean section; the length of labour tended to be shorter than in a control group of other primiparae; and the prematurity rate was less than in the control group. Nearly all his patients had an episiotomy. A finding of interest was how little upset emotionally were these young mothers as a result of pregnancy, labour, or the puerperium. Though forceps delivery was used in most of the cases early in the series to minimize the emotional trauma of delivery, this was later found to be unnecessary.

Further investigation of teen-age pregnancy in different communities would be valuable in defining the true risks of childbearing in the young. Results from different areas may well not be comparable. Until the evidence is more clear-cut the teen-age girl who is pregnant must be watched with a wary eye. There may be a too easy tendency to assume that youth by itself may be sufficient to overcome all the obstetric difficulties. The factors known to influence the obstetric outcome—such as height of the mother, social class, work during pregnancy, and illegitimacy[7]—all have their effects independently of age and must be given their due weight however young the mother may be. In particular, since there is a correlation between the adequacy of care before and during labour and obstetric results,[8] these mothers and their babies must receive the best possible care, though this may be difficult when social factors operate to prevent early attendance at antenatal clinics. Delivery at home should be considered only rarely for this group of patients because of the combination of social and obstetric problems which beset them.

The shadows cast by early childbearing, whether legitimate or illegitimate, fall on many fields. Any full understanding must include considerations of contraception for adolescents[9]; illegitimacy and its effects on mother, putative father, and families; housing for the young; the care of babies by the inexperienced; adoption; and obstetric care. Later will probably come a higher divorce rate, large families, and an increase in the incidence of cervical cancer and possibly of utero-vaginal prolapse.

Child Deaths and Infection

The infant mortality in Great Britain, though considerably lower than in the United States and most European countries, is much higher than in Scandinavia. The reasons are not altogether clear. A major cause of deaths in the newborn period is prematurity—and the premature-delivery rate is higher in Britain than, say, in Norway. Here an important

[1] *The Registrar-General's Statistical Review of England and Wales for the Year 1961*, Part II, 1963. H.M.S.O., London.
[2] *The Registrar-General's Statistical Review of England and Wales for the Year 1962*, Part II, 1964. H.M.S.O., London.
[3] *The Registrar-General's Statistical Review of England and Wales for the Year 1963*, Part II, 1965. H.M.S.O., London.
[4] Tanner, J. M., *Growth at Adolescence*, 2nd edition, 1962. Blackwell, Oxford.
[5] Wallace, H. M., *Amer. J. Obstet. Gynec.*, 1965, **92**, 1125.
[6] Stearn, R. H., *Lancet*, 1963, **2**, 1083.
[7] Kincaid, J. C., *Brit. med. J.*, 1965, **1**, 1057.
[8] Butler, N. R., and Bonham, D. G., *Perinatal Mortality*, 1963. Livingstone, London.
[9] Schofield, M., *The Sexual Behaviour of Young People*, 1965. Longmans, London.