SIR,—I can understand and have some sympathy with the irritated comments of Dr. P. M. S. Gillam (11 March, p. 685) on the two trials of clofibrate in the treatment of ischaemic heart disease. One finds that not only patients but also some doctors (who cannot have read the two papers) are expecting that the symptom of angina will improve as soon as the drug is consumed. There is no evidence and has been no claim for this whatever.

But I must answer his criticism of the Newcastle trial, for which I bear much responsibility. Regarding "the most important criticism"—namely, that non-cardiac deaths have not been reported—the facts are that I have records of seven patients who withdrew because of illness and later died—four of them in the clofibrate group (three dying of cancer) and three in the placebo (one dying of cancer). If these figures, which are I suspect incomplete, are added to the Scottish ones, which are believed to be complete, then we have 12 known deaths in the clofibrate group (six from cancer and four from cerebrovascular accidents) and 13 in the placebo (six from cancer and two from cerebrovascular accidents).

Doubtless some patients in both trials who withdrew for reasons other than illness died later of non-cardiac causes before the 5½ years of the trials were completed, the most frequent causes being, as in the above list, cancer and cerebrovascular accidents. One can only say that there is no evidence at all that clofibrate either prevents or precipitates these maladies.

The wisdom of admitting patients to the trial on the basis of history alone can indeed be questioned but less than a quarter of the patients had normal E.C.G.s, and it is hard to believe that when all of them were personally selected by experienced consultant physicians as suitable for a trial more than a tiny fraction would be wrongly diagnosed.

Regarding status on entry, some of the parameters were so obviously similar in the treated and controlled groups as not to need statistical analysis. In the remainder, including for example smoking habits on entry, statistical tests were applied, and in no instances were differences significant at the 5% level discovered.

Regarding the subsequent fate of the clofibrate patients who withdrew from the trial, it is difficult to see how this can have much bearing on the conclusions. The great majority of them certainly discontinued the drug. If they fared better than the placebo group it would strengthen the trial results in which Dr. Gillan does not believe. If they fared worse it could, as with anticoagulant therapy, be attributed to a rebound ill effect from stopping treatment. It seemed to us best just to disregard them.

Finally Dr. M. F. Oliver and I were well aware of the dubiety of combining the results of two trials whose criteria of entry differed. We did not therefore combine the figures, except in one instance—the non-fatal infarcts. We simply set them close together for easy comparison, and for the same reason preceded them with a full exposition of those differing criteria.

Dr. W. H. S. St. John-Brooks's strictures (18 March, p. 750) cover some of the same points, but he also refers to others of some importance. He states that in the relatively few females in the trial and in those patients on anticoagulants the causative factors and the course of their ischaemic heart disease might well differ significantly from what they would be in the uncoagulated males. This is very true, and it is one of our regrets that in the design of the trial females were included. It was our hope that patients on anticoagulants would not be included but the trial was mounted at a time when there was more confidence in their value than there is today, and several physicians did not care for that treatment to be discontinued on entry, and some patients were put on it during the course of the trial when they were doing badly. Because of this, as Dr. St. John-Brooks noted, the mortality of those on anticoagulants was greater than that of the remainder. It was also, he may note, equal in the clofibrate and the placebo groups. Because this anticoagulant group comprised so many with a poor prognosis it seemed to us wisest in the analysis to include them. For the same reason we included against Dr. St. John-Brocks's objections, those who withdrew from the trial up to the time of that withdrawal. If clofibrate had made the patients so much worse from repeated infarcts and/or angina that they had insisted on withdrawing would Dr. St. John-Brocks have wished them still to be excluded? One cannot have it both ways.

Finally his composite statement of some of the Newcastle results is founded on the selection of those where the advantage to clofibrate attained statistical significance. There were several others where owing to lack of numbers the advantage, though clear and consistent, did not attain this level.

In the same way, though it is true that some of the advantageous results could have been thrown up by chance, it is unlikely that this would have happened to the same results in both the Newcastle and Scottish trials, and it is for this reason that we think that the protection, especially against sudden death, afforded to patients with angina is probably genuine. Like Dr. Oliver I would be delighted if a new trial of male patients with angina only could be mounted to confirm this point.—I am, etc.,

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Termination of Pregnancy

SIR,—Professor Stallworthy and others'[1] indication that there is an element of serious risk attached to some operations for pregnancy termination gives cause for very real concern. The report from Mr. S. V. Sood (30 October 1971, p. 270) is likewise rather disturbing, and Beric and Kupresanin,[2] Dr. S. Lewis and colleagues (4 December, p. 606), and Dr. K. C. Loung and others (20 November, p. 477) have mentioned an appreciable incidence of complication with abortion procedures.

It may therefore be appropriate to report a personal series of 1,000 consecutive pregnancy terminations by curettage in which there was no case of cervical trauma, uterine perforation, or excessive blood loss, and in which no transfusions or laparotomies were required.

These cases were all operated upon for the Birmingham Pregnancy Advisory Service between 1 August 1970 and 31 December 1971 at four private nursing homes. There were no significant complications at operation or during the 24-hour admission period, and no patient needed to be detained. The only readmissions reported were one patient accommodated overnight for transient pelvic pain and another having a repeat curettage at a National Health Service hospital without retained products being found. Most of the patients came from the Midlands and over 70% gave permission for their general practitioner to be informed. Follow-up information is being sought from these doctors.

Analysis of data submitted for publication shows the largest age group to be 20-24 years with 12 patients aged only 14 or 15 years. Sixty-three per cent. of the patients were single, divorced, separated, or widowed. Housewives comprised 22·5% and office workers 21·8%, while there were 19 schoolgirls. There were 561 nulliparae and 439 multiparae in the series, with 1,049 existing children. Recommendations for legal abortions were made under Section 2 for 76·4% of the patients and under Sections 2 and 3 jointly for the remainder—general practitioners referring 53·5% of cases and half of them signing Certificate A. Most of the pregnancies were terminated between 9 and 12 weeks of gestation, but there were 139 cases of 13 or 14 weeks and 11 cases of 15 or 16 weeks. Seventy-two per cent. of the patients had not previously practised reliable contraception (16 October, p. 156).

It is accepted that there may well have been pyrexia or other complications following discharge from the clinics, and of course long-term effects may occur as a result of the surgical intervention. Such facts are extremely difficult to obtain from patients who have had a legal abortion, but in view of reports from European countries[3] some attempt must be made. To this end it would be helpful if the Lane Committee, in its report, recommended compulsory notification of pregnancy and certain other related conditions occurring at any time following legal abortion. This would have to be done without disclosing the names of patients.

If the Royal College of General Practitioners would co-operate in obtaining reliable clinical data the possible incidence of infertility, recurrent abortion, chronic pelvic sepsis, cervical incompetence, dystocia and other complications in childbirth, as well as any emotional effects on patients, could be more accurately assessed.

The above findings support the view that with scrupulous attention to technique it should be possible for individual surgeons to carry out 1,000 consecutive terminations by curettage without any immediate complication. Once this particular fact is recognized, the potential physical and emotional sequelae of the abortion procedure need to be evaluated scientifically in order to resolve current controversies.—I am, etc.,

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1 Stallworthy, J. A., Moolgaoker, A. S., and Walsh, J. J., *Lancet*, 1971, 2, 1245.
2 Beric, B. M., and Kupresanin, M., *Lancet*, 1971, 2, 619.
3 Kotasek, A., *International Journal of Gynaecology and Obstetrics*, 1971, 9, 118.

Acute Renal Failure and Open Heart Surgery

SIR,—Mr. E. D. Yeboah and colleagues (12 February, p. 415) have had a difficult task to analyse the Hammersmith Hospital open heart surgery cases retrospectively and have produced interesting and not unexpectedly