

elderly mother cannot be recouped as it might be partially in the younger one.

There were fortunately no maternal deaths in the Canadian series, but there is a raised risk for mothers simply on grounds of age, for there is an increased likelihood of hypertension, pre-eclampsia, and fibroids. Moreover, when labour is allowed to proceed it may be about 25% longer on average than in the younger woman.² The caesarean section and forceps rates are high, as is the incidence of induction of labour, often for hypertension. Morrison found a forceps rate of 30% and an induction rate of 19%—not, perhaps, very high, given changing practices and the obstetrician's predilections—but his caesarean rate of 31% is high by most standards, though it accords with the usual practice in these patients. However, while caesarean section may help both mother and baby escape some of the obstetric difficulties, it is by no means a panacea.

The overall perinatal mortality rate in these 127 patients was 94/1000 and even when corrected by taking out those weighing less than 1000 g it was still 47/1000, perhaps about twice the average. The number of small babies emphasizes that elderly primigravidae are prone to have light-for-dates infants, again perhaps about twice the usual average at 11%, though in this series it was more than five times the proportion in controls. Often the babies may be sickly or congenitally abnormal, and 18% had an Apgar score of less than 6 at one minute, while 3% had abnormalities with one cleft palate and one case of Down's syndrome.

It is important to retain a sense of perspective. Ideally all mothers and babies would survive and be healthy, but this prospect is still over the horizon. In the series out of a total of six stillbirths and six neonatal deaths only one infant was mature, so that only one of the 115 mothers who went through pregnancy to term lost her baby. While the elderly primigravida may appear to be specially at risk, she is still only a part of the general problems of hypertension, pre-eclampsia, premature labour, congenital abnormality, and light-for-dates babies which may afflict many women in pregnancy, whatever their ages. If these conditions could be brought under control it seems probable that the elderly primigravida might no longer be a worry, even though the methods of treatment for her and her baby might still need to be used in different proportions from those required for her younger associates in childbirth.

¹ Morrison, I., *American Journal of Obstetrics and Gynecology*, 1975, 121, 465.

² Donald, I., *Practical Obstetric Problems*, p. 91. London, Lloyd-Luke (Medical Books), 1969.

Outpatient Treatment of Haemorrhoids

With little exception, haemorrhoidectomy can no longer be regarded as the treatment of choice for second and third-degree piles. Inpatient procedures require an N.H.S. bed, now costing more than £30 per day, while excellent results of "ambulant proctology" indicate the clear advantages of procedures such as rubber-band ligation,¹⁻⁴ cryosurgery,^{5,6} anal dilatation,⁷⁻¹⁰ and internal sphincterotomy.^{11,12}

Reviewing the long-term results of rubber-band ligation of haemorrhoids, Steinberg *et al.*¹³ found that three and a half to six years after treatment 89% of patients were cured or satisfied, though complete absence of symptoms was noted in only

44%. Two per cent. underwent subsequent haemorrhoidectomy, and 12% had further conservative treatment for recurrent symptoms. Patients whose presenting complaint had been bleeding enjoyed the same improvement or cure rate as those who had presented with irritation or pain, and the results in patients with third-degree haemorrhoids were as good as those with second-degree ones.

Rubber-band ligation is a quick, simple procedure, requiring no anaesthetic; it can be undertaken by an experienced general practitioner,¹³ provided adequate anorectal examination is performed to exclude neoplasm or proctocolitis. More than one session of application may be required, depending on the presence of symptoms. Mild discomfort frequently occurs after ligation, but complications are rare^{14,15}; the patient usually returns to work on the next day.⁴ Cryosurgery provides effective treatment of haemorrhoids and skin tags, but the main disadvantage to the patient is the inevitable consequent watery discharge, lasting up to several weeks.⁵ Barron¹⁶ has claimed that this discharge may be reduced if rubber-band ligation is employed before cryosurgery.

Manual dilatation of the anus is performed under anaesthesia; the patients are advised to use an anal dilator for six months in order to prevent recurrent symptoms. Symptoms are undoubtedly improved, and the patients lose little time from work, but transitory mucus leakage was noted in 6% of one series.¹⁰ Internal sphincterotomy can be performed under local anaesthesia and has been successfully used to treat symptomatic haemorrhoids. Troublesome skin tags can be readily excised as an outpatient procedure under local anaesthesia.

Once it is accepted that haemorrhoids should not be treated unless they produce symptoms, and that it is unnecessary to remove haemorrhoids completely in order to relieve symptoms, then it becomes clear that many patients are undergoing needless haemorrhoidectomies. When an operation is justified outpatient treatment is more attractive to the patient. If more notice were taken of these facts, enormous sums of money could be saved annually by reducing the number of hospital admissions and waiting lists and by reducing the average time spent off work by patients with piles from weeks to one or two days.

¹ Barron, J., *American Journal of Surgery*, 1963, 105, 563.

² Panda, A. P., *et al.*, *Gut*, 1974, 15, 346.

³ Groves, A. R., *et al.*, *British Journal of Surgery*, 1971, 58, 923.

⁴ Gehamy, R. A., and Weakley, F. L., *Diseases of the Colon and Rectum*, 1974, 17, 347.

⁵ Lewis, M. I., *Diseases of the Colon and Rectum*, 1972, 15, 128.

⁶ Williams, K. L., *et al.*, *British Medical Journal*, 1973, 1, 666.

⁷ Lord, P. H., *Proceedings of the Royal Society of Medicine*, 1968, 61, 935.

⁸ Lannon, J., and Lewis, H. M., *South African Journal of Surgery*, 1972, 10, 205.

⁹ MacIntyre, I. M. C., and Balfour, T. W., *Lancet*, 1972, 1, 1094.

¹⁰ Sames, P., *Proceedings of the Royal Society of Medicine*, 1972, 65, 782.

¹¹ Hochuli, R., and Allgöwer, M., *Helvetica Chirurgica Acta*, 1968, 35, 266.

¹² Eisenhammer, S., *Diseases of the Colon and Rectum*, 1974, 17, 493.

¹³ Steinberg, D. M., *et al.*, *British Journal of Surgery*, 1975, 62, 144.

¹⁴ Dencker, H., *et al.*, *Acta Chirurgica Scandinavica*, 1973, 139, 742.

¹⁵ Lee, M., *British Journal of Clinical Practice*, 1971, 25, 542.

¹⁶ Barron, J., *Diseases of the Colon and Rectum*, 1973, 16, 178.

Oestrogenic Potency and Oral Contraceptives

By 1973, of women of childbearing age in Britain 16% were taking oral contraceptives and more than 50 million all over the world were on the pill: this in spite of the fact that these steroid combinations had been shown to have a range of