Clinical Topics

Disproportion in the falling birth rate

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Summary

Since 1962 there has been a disproportionately greater fall in the number of small (<1000 g) live births than total live births: this has applied to Sheffield and to England and Wales but more to the former. This may have affected falling neonatal mortality rates.

Introduction

The recent peak year for births in England and Wales was 1964 with 875 972 live births: in 1975 there were 603 448. In a recent paper¹ the fall in live births in one Sheffield maternity unit was shown to be disproportionately greater in those of very low birth weight. I wanted to discover whether a similar disproportionate fall had also occurred in other Sheffield units and in England and Wales.

Material

All figures were obtained either from DHSS reports^{2,3} or the Sheffield Office of Population, Censuses, and Statistics. From 1953 records are available of all live births weighing 2500 g or less. I have divided this group into three subgroups of 2000-2500 g, 1500-2000 g, and 1500 g or less. From 1963 figures for 1000-1500 g and 1000 g or less are also available.

Results

The year of maximum births in Sheffield was 1967 not 1964. In each case the percentage fall in live births is from the maximum year to 1975. For Sheffield the falls are greater than for England and Wales, especially in the smaller weight groups. For England and Wales only the 1000 g or less group shows the disproportionate fall (table I).

Percentage fall in live births in the different weight groups in England and Wales and in Sheffield

	England and Wales (1964-75)	Sheffield (1967-75)
Total live births	31.16	36.25
≤ 2500 g	31.96	44.25
2001-2500 g	32.09	45.66
1501-2000 g	30.71	22.83
≤ 1500 g	33.11	65.38
(1001-1500 g)	29.11	64.91
(≤ 1000 g)	39.95	66.66

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FIG 1—Comparison of the annual numbers in the 2500 g or less group with the total number of live births (all weights).

FIG 2—Comparison of the annual numbers in the 2001-2500 g group with the total number of live births (all weights).

FIG 3—Comparison of the annual numbers in the 1500 g or less group with the total number of live births (all weights).

FIG 4—Number of stillbirths and neonatal deaths (1/12) weighing 1500 g or less.

For England and Wales numbers in the 2500 g or less failed to rise after 1961 and started to fall before the numbers in the total live births group. Since 1970 the numbers in both groups have fallen together (fig 1). Numbers in the 2000-2500 g group rose and fell with the total live birth group (fig 2). The cause of the 2500 g or less group failing to rise after 1961 appears to lie with the 1500 g or less group (fig 3). In case these falls might be thought to be due to a changing fashion in diagnosis, stillbirths and live births over the years have maintained the same relationship to each other in the 1500 g or less group (fig 4).

Discussion

What can be the explanation of these facts? 1953-61 was the period of rising births with a uniform increase in all weight groups. During the period 1961-70 the contraceptive pill became available in Britain. The first effect may have been to

reduce the number of very small infants. This probably resulted from a reduction in the number of late, illegal abortions. The Abortion Act of 1967 with an expanded use of contraception must be responsible for the recent plunge from 1971 to 1975. But this by itself would not explain the disproportionate drop in the very small births, which again is probably due to the virtual disappearance of illegal abortion.

On this basis the much greater fall in Sheffield may be due to the greater necessity for, and availability of, illegal abortion in the cities before 1967.

But, of course, there must be more to it than that. Improvement in general health, proper spacing of pregnancies, adequate antenatal care, and great improvement in the obstetric services may all have helped to reduce the incidence of spontaneous premature labour. Future developments should reduce this even more.⁴

If the national figures develop along the same lines as Sheffield the number of very small infants is going to be drastically reduced in the future. Were that to happen the superintensive care units for preterm infants envisaged in the Court Report⁵ and other DHSS publications⁶ may be unnecessary. If they are established it may be impossible to measure their worth because what they would set out to do may well be occurring already.

References

- ¹ Gordon, R R, *British Medical Journal*, 1977, **1**, 1313.
- ² Committee on Child Health Service, *Fit for the Future*, vol 2, p 82, Cmnd 6684. London, HMSO, 1976.
- ³ Alberman, Eva, *Health Trends*, 1974, **6**, 14.
- ⁴ *British Medical Journal*, 1977, **1**, 1118.
- ⁵ Committee on Child Health Service, *Fit for the Future*, vol 1, p 370, Cmnd 6684. London, HMSO, 1976.
- ⁶ DHSS, *Report of Working Party on Prevention of Neonatal Mortality and Morbidity*, HC (76) 40. London, HMSO, 1976.

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Post-"pill" amenorrhoea—cause or coincidence?

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Summary

The relationship of contraceptive history to diagnostic category of amenorrhoea was analysed in 131 consecutively investigated cases of secondary amenorrhoea. Amenorrhoea occurred in 52 patients immediately after discontinuing the oral contraceptive. Twenty-two had had amenorrhoea before oral contraceptive treatment

and 23 patients before the episode of non-contraceptive-related amenorrhoea investigated here. When these cases were excluded from analysis there was no significant difference in the distribution of any of the diagnostic categories between those who had used the oral contraceptive and those who had not.

The results suggest that using oral contraceptives does not cause subsequent amenorrhoea.

Introduction

Many patients develop post-"pill" amenorrhoea (PPA)—that is, secondary amenorrhoea immediately after stopping oral contraceptives.¹⁻³ Usually it has been concluded that the amenorrhoea was caused by the contraceptive. With few exceptions,^{3,4} however, there has been no attempt to compare the clinical and endocrine features of patients with PPA with those in a comparable group of patients with amenorrhoea who have not taken the oral contraceptive (OC). We report the results of our analysis of 150 patients with secondary amenorrhoea and compare the distribution of various diagnostic categories in

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