With regard to the "popular fallacies," it is probable that cephalopelvic disproportion is less common in Dublin than in some centres in Great Britain. During 1910¹ 4,449 deliveries occurred in the combined extern and intern departments of the Rotunda Hospital.² There were five caesarean sections, the forceps rate was 3.6%, the stillbirth rate 3.2%, and the hospital perinatal mortality rate was 4.8%. Such figures would not have been possible in Glasgow in 1911. Further, women of certain African tribes can expel infants through markedly contracted pelves, and large amounts of an oxytocic drug could mask slight degrees of cephalopelvic disproportion. Even if rupture of the primigravid uterus is uncommon it is reasonable to conclude that damage done during the first delivery might conduce to rupture in subsequent pregnancies.

It is difficult to grasp how a standard concentration of 10 units of oxytocin in a litre of glucose solution "increases the margin of safety" unless Mr. O'Driscoll has discovered some special means of controlling the drip rate which has eluded others. A variation in it of from 5 to 10 drops a minute would alter the amount of oxytocin delivered by from 3 to 6 mU./min. The authors give no indication as to what percentage of women were given 50 mU. oxytocin/min. and for how long, whether the infusion rate was lowered when uterine activity increased, how frequently foetal distress necessitated slowing of the drip and/or operative interference, and how uterine activity was monitored, whether electronically or by the hands of students or nurses.

Seeing that amniotomy *per se* increases the sensitivity of the human myometrium to oxytocin,³ it is clearly more dangerous to give massive amounts of oxytocin after the membranes have been ruptured than before amniotomy. Amniotomy followed by an oxytocin drop (or infusion), either to induce or to enhance labour, was started at Bradford and remains the Bradford technique whether 50 mU. instead of 5 mU. oxytocin/min. are infused (there are 450 million mU. in one gram of oxytocin), the only difference being in safety. Apart from trauma to mother or infant it is beyond doubt that such amounts of oxytocin are antidiuretic,⁴ and the delivery of 80 drops a minute of the recommended solution, or one litre in just over 3½ hours, might cause marked water retention which could not benefit the mother.

The vast majority of deliveries in Britain are done in non-teaching hospitals, and it is idle to expect that a special care unit comparable with that at the National Maternity Hospital, Dublin, could be staffed in many of them. You, Sir, in your leading article (9 August, p. 315) suggest that "the excellent results reported by O'Driscoll may be due as much to the high standards of supervision as to the active policies adopted," and with this observation many of your readers will agree. The fact that 796 out of 915 primigravidae in labour proceeded in normal labour without either amniotomy or oxytocin highlights the essential difference between the several groups. It is reasonably certain that endogenous oxytocin does not put a woman into labour but rather that physico-chemical changes in and around the myometrial cells sensitize the human myometrium to the amounts of oxytocin which normally circulate in the blood and which probably never reach 2 microunits/ml. blood.⁵

The real problem is why the uterus tolerates the foetus, and when that is understood it may be possible to use physiological means to induce labour-readiness measured by myometrial sensitivity to oxytocin. Having

the privilege of knowing Mr. O'Driscoll, I am convinced that he would be the last person to encourage harassed, inadequately equipped, and understaffed hospitals to conduct labour with a stop-watch in hand and to venture on the use of a hormone as a drug in order to achieve chemical *accouchement forcé*.—I am, etc.,

G. W. THEOBALD.

University College Hospital
Medical School,
Obstetric Hospital,
London W.C.1.

REFERENCES

- ¹ Theobald, G. W., Kelsey, H. A., and Muirhead, J. M. B., *Journal of Obstetrics and Gynaecology of the British Empire*, 1956, **63**, 641.
- ² Jellett, H., Solomons, B. A. H., Madill, D. G., and Rowlette, R. J., *Clinical and Pathological Reports of the Rotunda Hospital, Dublin*, Falconer, 1912.
- ³ Theobald, G. W., Robards, M. F., and Suter, P. E. N., *Journal of Obstetrics and Gynaecology of the British Commonwealth*, 1969, **76**, 385.
- ⁴ Theobald, G. W., *Journal of Physiology*, 1959, **149**, 443.
- ⁵ Howarth, A. T., Lundborg, R. A., and Theobald, G. W., *Journal of Physiology*, 1963, **168**, 16.

SIR,—Mr. K. O'Driscoll and others (24 May (p. 477) have reported the use of pharmacological concentrations of intravenous oxytocin (3.1 mμ–50 mμ/min.) in preventing prolonged labour, and you have commented on this in a leading article (9 August, p. 315).

In Southampton the regimen of oxytocin therapy advocated by Mr. O'Driscoll has been used since late May of this year in 40 patients. Of these patients 19 were primigravidae and 21 were multigravidae. In this series there has been no evidence of uterine or foetal damage. The results support Mr. O'Driscoll's observations that delivery can generally be expected within six hours of setting up the drip. However, two patients were delivered by caesarean section on account of foetal heart irregularity early in labour. It may be significant that both these were elderly primigravidae with "precious babies," and it was felt abdominal delivery was conservative in the absence of sophisticated means for assessing foetal wellbeing.

This series has mainly been confined to patients having amniotomy as a means of inducing labour, indicated by abnormal glucose tolerance, apparent prolonged pregnancy, and pre-eclampsia. In addition, five patients with already prolonged labour were treated.

In a group of seven patients with evidence of pre-eclampsia we combined oxytocin-promoted labour with lumbar epidural block anaesthesia. This combination has the advantage of lower levels of blood pressure and absence of painful stimuli, both desirable in the pre-eclamptic. The oxytocin concentrations advocated by Mr. O'Driscoll do seem to raise the level of blood pressure in labour, and conduction anaesthesia may remove this possible objection to their use.

It is felt that this experience in a busy provincial centre in England might be relevant to the discussion on active management obstetrics. Though the policies advocated by Mr. O'Driscoll involve closer attention by both doctors and midwives, this further step towards planned obstetrics has considerable advantages in the busy city maternity units characteristic of Britain.—I am, etc.,

BEVERLEY N. C. LITTLEPAGE.

Southampton General Hospital,
Southampton, Hants.

Oral Contraceptives and Thromboembolism

SIR,—Although Drs. M. P. Vessey and Richard Doll (14 June, p. 651) have found that the incidence of thromboembolism in patients admitted to hospital does not vary greatly with age or parity, this is not so for all patients with thromboembolism brought to general practitioners and from which hospital admissions are selected. In the communication of the Royal College of General Practitioners' Research Unit, 1967,¹ in which the relationship between thromboembolism and use of oral contraceptives was first established at a significant level, it was shown that rates per 1,000 population at risk increased with age and with parity. The Table gives the estimated rates for married women between the ages of 15 and 50 using the data collected in the above-mentioned study. Results are given separately for patients with venous thromboemboli: (1) seen during pregnancy and the puerperium, (2) using oral contraceptives, and (3) all others. The respective populations at risk were estimated by applying to the total population of the practices concerned in the study (1) national birth rates by age, and parity (Registrar General's *Statistical Review*, 1966), and (2) information about oral contraceptive usage during 1965–6 obtained from various papers quoted as references in the paper under discussion.

Age Group	Population at Risk (Married Women)	Patients with Venous Thromboembolism (Rates per 1,000 Population)		
		Pregnant or Puerperal	Oral Contraceptive Users	Others
15–29	12748	3.9 (14)	2.1 (2)	0.6 (5)
30–39	15756	8.8 (11)	5.9 (7)	1.1 (15)
40–49	15811	32.5 (4)	14.7 (7)	3.4 (52)
N.K.		(1)		(3)
All ages	44315	6.1 (30)	6.1 (16)	2.0 (75)

The numbers of patients are shown in parentheses.

For each group of patients rates increase with age, although it must be admitted that some of the numbers of patients concerned are small. The numbers of married women aged 15–49 in each parity group have also been estimated, and the following rates were obtained for those who were neither pregnant during a 12-month period nor using oral contraceptives; the numbers of cases are shown in brackets. An increasing trend in the rates with increasing parity is evident.

Drs. Vessey and Doll found that five married women per 100,000 at risk in the age group 15–40 were admitted to hospital with thromboembolic disorders without evident cause. We have assumed that this is equivalent to our category: not pregnant or puerperal, and not on oral contraceptives. We estimate the total in this group to be 93 per 100,000 at risk. The equivalent figures for married women on oral contraceptives are 57 per 100,000 admitted to hospital in the Vessey and Doll study, and our estimated total of 424 per 100,000 at risk. There would therefore seem to be a bias of 2.5 to 1 in favour of a woman with thromboembolism and taking oral contraceptives being admitted to hospital compared with women who are not using oral contraceptives.

The relative risk of hospital admission estimated by Drs. Vessey and Doll, using a direct comparison of affected and control patients, was 6.3 to 1, with 95% confidence levels between 3.4 and 11.6 to 1, and they state that "other evidence suggests that the true risk

is likely to be nearer the upper than the lower of these limits." The comparable ratio between affected and control patients in our original study was 3 to 1, which again suggests a bias of 2-3 to 1.

Parity	Rates (per 1,000 Population)
0	0.7 (5)
1	1.5 (15)
2	1.9 (21)
3	2.9 (15)
4 and over	5.0 (18)
Not known	(1)

The only alternative explanation to a bias would be that thromboembolic episodes produced in oral contraceptive users were more severe than those produced by pregnancy or the puerperium or in those who are suffering from so-called idiopathic thromboembolism. In the earlier paper¹ we showed that when patients who were pregnant were excluded the proportions in each category of severity for oral contraceptives and non-oral contraceptive users were similar, and supported the assumption that there was no over-reporting or recording by general practitioners of thromboembolic disorders in patients on oral contraceptives compared with those not using oral contraceptives.

We would stress that the estimates in our earlier study, and also in the present study by Drs. Vessey and Doll, are both based on relatively small numbers of patients in any one category. We feel that most of the difference in these two estimates is attributable to the increased admission rates for women on oral contraceptives, compared with those who are not using them, when they get a thromboembolic episode. The differences in the College study are certainly not due to any increased severity in these episodes in oral contraceptive users compared with non-oral contraceptive users.—We are, etc.,

D. L. CROMBIE.
K. W. CROSS.

Royal College of General Practitioners
General Practice Research Unit,
Birmingham 16.

REFERENCE

- ¹ Royal College of General Practitioners, *Journal of the College of General Practitioners*, 1967, 13, 267.

Nasal Obstruction in Babies

SIR,—In concluding their medical memorandum Mr. B. D. Birt and Dr. Eveline B. Knight-Jones (2 August, p. 281) describe three methods of nursing babies with nasal obstruction, and a recent article from Sweden recommends tracheostomy as the method of choice.¹

I wonder if any of these techniques are necessary. In this hospital there have been three babies in the last twelve months with bilateral choanal atresia, each with severe respiratory obstruction, and each was treated by inserting an oral airway (Guedel type) and holding it in place with a tape round the neck. One baby had multiple deformities and subsequently died, but the airway was no problem. The other two went home.

These airways are very well tolerated by babies, which is not surprising considering the popularity of dummies. When a few weeks old both started to learn the art of mouth breathing. So satisfactory was the

method that one parent began to question the need for operation. This method is certainly simpler and safer than those mentioned, and infinitely preferable to the barbarous technique of forcing a trochar blindly through the nose.

Though respiratory obstruction is severe in such cases it is not always fatal. I have operated on one young Irish seaman with bilateral choanal atresia, and gathered that his nasal obstruction had never been considered more than a joke.—I am, etc.,

ANTHONY E. HOWARTH.

Children's Hospital,
London S.E.26.

REFERENCE

- ¹ Hogeman, K. E., and Toremalm, N. G., *Journal of Laryngology and Otology*, 1968, 82, 913.

Oestrogens and Prostatic Hypertrophy

SIR,—Under the heading of "Oestrogen Treatment of the Male" (Today's Drugs, 2 August, p. 285) the writer says: "Because of their feminizing action oestrogens should be given to males only in special circumstances, such as carcinoma of the prostate and prostatic hypertrophy, where they may be useful in controlling the disease."

As a practising urologist I am surprised that the writer recommends use of oestrogens in simple prostatic hypertrophy, for they have never been shown to be of any value, and, moreover, as he says, may, among other things, produce hypertrophy of the breasts and cause considerable embarrassment to the patient without doing him any good at all.

I cannot too strongly deprecate the use of oestrogens in simple prostatic hypertrophy, and I hope that you will draw the attention of your readers to this, for I think that it could cause considerable trouble.—I am, etc.,

S. HENRY C. CLARKE.

Brighton, Lewes, and
Mid-Sussex Hospitals,
Sussex.

Malignant Granuloma

SIR,—I read with some interest the leading article on malignant granuloma (2 August, p. 254) and the subsequent brief correspondence (23 August, p. 471), as I have reported several cases.^{1,2} One of these cases is still alive and well, having had no further trouble since treatment with a very small dose of irradiation. This is, by many years, the longest surviving case ever recorded. Several other cases of mid-line granuloma have been treated similarly with equal success, though one or two others have failed to respond.

I realize that many other methods have since been developed, but, as none of the results has approached anywhere near the success of the cases I reported, perhaps the treatment then suggested should not be completely overlooked as it has been in your leading article and the subsequent correspondence.—I am, etc.,

MAXWELL ELLIS.

London W.1.

REFERENCES

- ¹ Ellis, M., *British Medical Journal*, 1955, 1, 1251.
² Ellis, M., *Annals of Otolaryngology, Rhinology, and Laryngology*, 1957, 66, 1002.

SIR,—Dr. C. H. Brown (23 August, p. 471) believes in antibiotic and chemotherapeutic treatment, combined with corticosteroids and cytotoxics. I agree with him, as I know from experience that steroids alone are useless. It should be emphasized that steroids and antimitotics both depress the immune mechanism. Thus a suitable antibiotic in maximum dose is essential. The results reported by Dr. C. H. Brown are very encouraging; it was brave of him to report them.—I am, etc.,

Epping, Essex.

FRANK MARSH.

Asymptomatic Bacteriuria

SIR,—For 18 months now all Manchester schoolchildren, at school entry, are having urine microscopy carried out at school medical examination.

They are screened for bacilluria, pyuria, and haematuria, as well as the routine tests. The children with pathological counts are then referred to one of three hospitals in the area which have a paediatric urology department. The children are then fully investigated, careful history is taken, and further urinary microscopy performed. If indicated, full renal investigations may then be undertaken.—I am, etc.,

R. EIREW.

Booth Hall Children's Hospital,
Manchester.

Febrile Convulsions

SIR,—It is a constant surprise to me that paediatricians—particularly the more eminent ones like Professor R. S. Illingworth (30 August, p. 529)—should still apparently believe that there is some subtle difference between the convulsions that a child gets when febrile and other manifestations of epilepsy. It is surely well recognized that the younger a patient is the lower the epileptic threshold, that fever—as well as some other things—lowers this threshold further, that in some of these patients one need not treat them too seriously, and that in these circumstances the prognosis is usually good.

To suggest, however, that these are not epilepsy is, though comforting to the parents, surely quite untenable. Or is it that they really know this quite well and are bending the truth for the sake of propaganda?—I am, etc.,

N. S. ALCOCK.

Royal Devon and
Exeter Hospital,
Exeter, Devon.

Intestinal Obstruction and Hypothyroidism

SIR,—We read with interest the case reported by Dr. J. S. Chadha and others (16 August, p. 398) and were reminded of a recent similar case of our own.

A 63-year-old female developed colicky abdominal pain one week before admission. For many years she had complained of constipation and intermittent abdominal distension. On admission the pain appeared to be slight compared to the degree of distension. The