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.,

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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.,

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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 Otology, 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.

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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.,

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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