

that an intrauterine contraceptive device may be inserted only up to five days after unprotected intercourse will restrict unnecessarily the use of this highly effective postcoital method. It is accepted clinical practice to fit the device up to five days after the calculated earliest date of ovulation.^{2,3} In emergencies where coital exposure took place more than five days previously, the shortest cycle length ever experienced by the woman must be ascertained and the day of ovulation calculated. An intrauterine contraceptive device can then be fitted up to five days after the earliest calculated date of ovulation. In a normal 28 day cycle this extends the time allowed for use of the device to day 19 of the cycle. This is of particular relevance when multiple exposures have occurred.

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SIR,—Dr Peter J M Davis expresses concern regarding the semantics used for describing postcoital contraception.¹ There would be more sympathy for his adoption of the "moral high ground" if his letter did not display numerous inconsistencies.

There are many translations of the Hippocratic oath and the one chosen by Dr Davis strongly supports his views. He should, however, examine the other passages of this pre-Christian philosopher's thoughts on medical ethics and ask himself how many of the normal day to day activities that he accepts as part of his routine work in general practice are, in fact, proscribed by the oath. If Hippocrates's thoughts on confidentiality are accepted as sacrosanct then it would be impossible to abide by the notifiable diseases legislation; his admonitions to accept the wisdom of his teachers could prevent a practitioner ever applying to go on an updating course. Perhaps Dr Davis does follow that particular part of the oath and that is why he still believes that modern intrauterine contraceptives work predominantly by preventing implantation. (Their major effect is in preventing sperm ascent through the genital tract, thus reducing the number of fertilisations.²)

I hope that Dr Davis's patients are fully informed of his views and therefore the limitations of the contraceptive "services" that he is actually prepared to provide before they sign any agreement. Hopefully the purchaser-provider philosophy will allow family health services authorities to clarify with family practitioners with such an attitude to contraception that they are offering only a limited service.

Perhaps we should not be too hard on the likes of Dr Davis for displaying inconsistency. The Hippocratic texts themselves describe and advocate methods of abortion for certain pregnant females (slave prostitutes).³ It was the Abortion Act 1967 that first legally enshrined this enthusiastically proclaimed right to exercise a conscience in treating patients and thus ignore another Hippocratic precept.

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Early pregnancy assessment units

SIR,—Ms M A Bigrigg and Mr M D Read set an enviable pace for long overdue improvements in the care of women with early pregnancy complications.¹ The improvement in shortened length of stay for treated and untreated women seems inarguable, but the results for savings of bed days by avoiding or reducing admissions are derived by extrapolating from a historical control group, probably with wide confidence intervals. The financial calculations based on the extrapolations may be oversimplified. Moreover, there is no complete comparison of the resource costs of providing the service with and without an early pregnancy assessment unit. For example, there seems to be no allowance for the resource costs of running the assessment unit, for the specific costs and effects of making ultrasonography and haematology services available seven days a week, or for undetected secondary changes in practice by general practitioners and hospital doctors.

The costing of bed days alone is a complex matter, and may even have been affected by the new system. A complete economic appraisal for cost effectiveness can also be complicated,² yet this exercise was not described in detail, which clouds its otherwise important message.

Although we are inspired by the initiative of Ms Bigrigg and Mr Read, we suspect that our local budget managers would require more complete analyses before rearranging the use of these resources.

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Unintended pregnancies and contraceptive use

SIR,—I know from discussions with Professor M Orme and Dr D J Back that it would be wrong so to misinterpret their recent letter¹ as to consider all gastrointestinal upsets and drug interactions unimportant as potential causes of failure of the contraceptive pill. Vomiting remains highly relevant—indeed, it was the commonest identifiable explanation for unplanned conception in a study of women taking the pill apparently consistently.² Though it is perfectly true that broad spectrum antibiotics reduce efficacy in only a tiny number of women, the prescriber does not know who these are. Enzyme inducers, especially rifampicin, griseofulvin, and most anticonvulsants, significantly reduce blood concentrations of both oestrogen and progesterone. So for short term use of any interacting drug it is prudent to recommend the usual advice given in leaflets of the United Kingdom Family Planning Association. This is to take extra contraceptive precautions throughout and for seven days after the drug treatment, with

elimination of the subsequent pill free interval if the last seven pills were implicated.³

Yet I agree with Professor Orme and Dr Back that we must seek other explanations for most of the breakthrough conceptions in Ms Anne Fleissig's study.⁴ I suggest that most were due to errors in taking the pill, specifically those causing lengthening of the pill free interval, which we now know to be a time when there is some return of follicular activity approaching close to actual ovulation in a few women.⁵ Unfortunately, few women are taught that being a bit late in starting the next packet is far more dangerous in terms of contraception than missing even several tablets in mid-packet. And if they make a break in taking the pill near the end of a packet few are aware that they should run on to the next packet with no (superimposed) regular pill free time that month.

Dr C. B. Everett asks, "Do we now need to increase the strength of oral contraceptives used by young women?"⁶ In my opinion this would be a retrograde step. Far more logical would be to direct attention to that pill free interval. For a start, all modern pills ought to be packaged for 22 days followed by a six day gap, as, helpfully, was the case with Organon's pill Minilyn (now withdrawn). This would increase the margin for error despite a negligible increase in hormone load; and there is an extra advantage for compliance in that the starting day is the same as the finishing day for each pack.

While we wait for the manufacturers to heed this oft repeated recommendation, if a woman has a breakthrough pregnancy it is even now the policy of the Margaret Pyke Centre to suggest that she "tricycles," using a monophasic pill. This means taking three or four packets in a row¹ followed by a (shortened) pill free interval. This simply reduces the number of pill free episodes, dangerous in terms of contraception, to four or five a year from the usual 13. This is vastly preferable to rebuking the woman, even when she admits to forgetting one or two tablets—as so many do this with impunity the ability to conceive probably indicates that that woman is regularly closer than average to ovulation at the end of each seven day pill free interval. If the pill free interval is less frequent and shorter there is a greater margin for error.

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Phosphate enemas in childhood

SIR,—We read with interest Dr M McCabe and colleagues' lesson of the week concerning phosphate enemas in childhood.¹ We became aware of the possible dangers of phosphate enemas whilst preparing our report on magnesium enemas.² In our original submission these dangers were mentioned, but pressure of space led to their not being included. It therefore came as a surprise to read that we had "implied that phosphate enemas might be an alternative" (to magnesium sulphate enemas). Our report questioned the justification of administering magnesium sulphate enemas to children, and it emphasised the importance of the accurate, specific prescribing of enemas and the checking of the type of enema to be given as the packaging of Fletcher's phosphate and magnesium sulphate enemas is very similar. This was the only mention of phosphate enemas—a