Clinical implications

- Medical abortion, using mifepristone and gemeprost, is a safe and effective alternative to surgical vacuum aspiration
- Up to a third of the 200 000 induced abortions performed in Britain each year could be undertaken medically
- In this study 20% of women preferred to use medical abortion and 26% vacuum aspiration; the remainder were willing to use either method
- Women who prefer to use a particular method should be allowed their choice if acceptability is to be maximised
- Women who are unsure which method to use are likely to find vacuum aspiration more acceptable at gestations of over 50 days' amenorrhoea

75-96% of women find medical abortion acceptable, with the corresponding figures for vacuum aspiration ranging from 96% to 100%.^{20 21}

This study suggests that 20% of British women prefer medical abortion and that a further 54% would be willing to use the method. That 26% of women would not contemplate medical abortion shows the importance of providing choice. Travelling distance was the only statistically significant characteristic which identified women with a preference for a method of abortion.

Both medical abortion and vacuum aspiration seem to be highly acceptable in women allocated according to preference. However, women without a preference, when allocated at random, found vacuum aspiration significantly more acceptable, especially at longer gestations; even so, medical abortion was acceptable to nearly three quarters of women.

This information is useful to clinicians who are required to give practical advice to women applying to have an abortion. Women who prefer a method of abortion should be allowed their choice, regardless of length of gestation. Women presenting very early (less than 50 days' amenorrhoea) may be reassured that they are likely to find the procedures equally acceptable; medical abortion is at its most effective at shorter gestations.⁶ Women of 50-63 days' gestation who are not sure which method to use may be advised that vacuum aspiration is likely to be more acceptable.

A simple randomised (or entirely pragmatic) trial would not have yielded these results. Hence, the

patient centred, partially randomised trial design advocated by Brewin and Bradley may be a useful tool in pragmatic research in populations characterised by an unwillingness to comply with all treatments under investigation.²²

Nearly a quarter of the women recruited into this study had had a previous induced abortion. The follow up recommended after medical abortion may provide an excellent opportunity to reinforce counselling about regular and emergency contraception.

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Clinical features, risk factors, and referral delay in British patients of Indian and European origin with angina matched for age and extent of coronary atheroma

Naeem Shaukat, D P de Bono, J K Cruickshank

Coronary artery disease is disproportionately prevalent in the United Kingdom in people originating from the Indian subcontinent^{1 2} and there are apparent differences in the risk factor profile.^{3 4} We have compared the clinical features and risk factors in patients of Indian origin who have had coronary angiography for sus-

pected angina with those of white patients with angina studied in the same clinic and matched for age and extent of coronary disease.

Patients, methods, and results

Coronary arteriograms of 154 consecutive patients of Indian origin studied at a regional cardiothoracic centre over two years were classified as normal (no stenosis greater than 50% in any vessel) or as showing single vessel disease (stenosis greater than 70% in only one coronary artery) or multivessel disease (stenosis greater than 70% in two or more coronary arteries). Thirty patients were chosen at random from each group. There were 51 Gujarati Hindus, 18 Punjabi Muslims, 14 Punjabi Sikhs, four Punjabi Hindus, and three Gujarati Muslims. Seventy (78%) were male. All were first generation immigrants. Ninety European

Correspondence to:
Professor D P de Bono,
Department of Cardiology,
University of Leicester,
Leicester LE3 9QP.

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	Findings at angiography								Adjusted odds ratio (95% confidence interval) (n=180)†		
	Normal		Single vessel disease		Multivessel disease		All levels combined				
	Indian origin (n=30)	White (n=30)	Indian origin (n=30)	White (n=30)	Indian origin (n=30)	White (n=30)	Indian origin (n=90)	White (n=90)			
No (%) of smokers	15 (50.0)	22 (73.3)	17 (56.7)	21 (70.0)	16 (53.3)	20 (66.7)	48 (53.3)	63 (70.0)	{ Not smoking Smoking ≤24.19 24.20-26.20 >26.20	1.00 0.35 (0.14 to 0.91) 1.00 2.87 (1.09 to 7.59) 2.70 (0.94 to 7.73)	
Mean body mass index*	26.3	24.2	25.2	22.9	26.3	24.3	25.4	24.9		{ ≤125 126-138 >138	1.00 0.78 (0.29 to 2.10) 0.28 (0.11 to 0.74)
Mean systolic blood pressure (mm Hg)	131.6	136.4	135.9	125.4	139.7	144.4	135.7	135.4		—	—
Mean diastolic blood pressure (mm Hg)	79.4	79.9	76.7	80.2	85.5	85.5	80.5	81.9	—	—	
No (%) of diabetics	4 (13.3)	2 (6.7)	3 (10.0)	3 (10.0)	20 (66.7)	13 (43.3)	27 (30.0)	18 (20.0)	{ Not diabetic Diabetic	1.00 3.16 (1.17 to 8.53)	
Mean total cholesterol (mmol/l)	5.50	5.59	5.94	5.83	6.67	6.79	6.10	6.10		—	—
Mean high density lipoprotein cholesterol (mmol/l)	1.29	1.31	1.14	1.16	1.03	0.91	1.09	1.13		—	—
Mean triglyceride (mmol/l)	1.57	1.70	2.13	1.86	2.82	2.29	2.19	1.97	—	—	
Mean referral interval (months)	11.6	6.1	13.0	7.6	27.6	7.0	17.4	6.9	{ <6 6-11 >11	1.00 2.03 (0.94 to 4.99) 5.31 (1.98 to 14.23)	

*Weight (kg)/(height (m))².
†Adjusted odds ratios show the association of Indian origin ethnicity with the factors listed, each adjusted for the others in the table.

patients having angiography for angina over the same period were matched for age (within two years), sex, and extent of coronary disease.

Smoking habits, weight, height, blood pressure, duration and nature of clinical symptoms, and history of previous myocardial infarction and of diabetes mellitus were noted at the time of coronary arteriography. The interval from onset of symptoms to referral was defined at the date that the patient was first seen in a cardiology clinic. Plasma glucose, total and high density lipoprotein cholesterol, and triglyceride concentrations were estimated in fasting blood samples taken before angiography. Glucose was measured enzymatically, total cholesterol and triglyceride concentrations by colorimetric assays (Cobas-Bio), and high density lipoprotein cholesterol by reassay after precipitation of non-high density lipoprotein cholesterol. Values for continuous variables (means) and categorical variables (whole numbers and percentages) are shown in the table.

The question addressed was: "is the risk factor profile in the Indian origin population of patients with angina different from that in Europeans with the same degree of disease sampled from the same referred population?" A conditional logistic regression model (EGRET: epidemiological, graphics, estimation, and testing package) was fitted to the data, ethnicity serving as the dependent variable and allowing for matching in respect of age, sex, and extent of coronary disease. This identified smoking status, diabetic status, and time from onset of symptoms to referral as the only factors having significant ($p < 0.05$) effects on the variance explained by the model. A subsidiary analysis, in which continuous variables were categorised into tertiles on the basis of their distribution in the whole study population, confirmed these relations—for example, between time from onset of symptoms to referral and Indian origin of the patient (see table: adjusted odds ratio for highest tertile (delay > 11 months) 5.31 (95% confidence interval 1.98 to 14.23)).

Comment

We acknowledge that our patients of Indian origin in this study were drawn from several different ethnic groups, but all of these have been associated with an increased risk of coronary disease. The importance of diabetes and an increased body mass index in Indian origin patients with angina has been noted before.^{3,5} The difference in time from symptom onset to consultation, which was longer and more variable in the Indian origin group, is cause for concern. We know that the interval between receipt of a referral letter and consultation in our clinic is identical (mean five weeks) in white and Indian origin patients. Referral bias by primary care doctors must be considered, but general practitioners in our area with large Indian origin practice populations tend to have average or above average referral rates. Alternatively, the longer referral delay may reflect natural stoicism, language difficulties, a reluctance to seek hospital treatment, or a lifestyle which avoids angina provoking exercise. This possibility should be explored, as it has important implications for health education and access to health care.

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**Department of Cardiology,
University of Leicester**
Naeem Shaikat, research fellow
D P de Bono, British Heart Foundation professor of cardiology

Clinical Epidemiology Unit, University of Manchester Medical School
JK Cruickshank, senior lecturer