

infarction in women of reproductive age could be prevented if all women stopped smoking. Secondly, the risk of infarct was not significantly increased in users of combined oral contraceptives compared with non-users. Thirdly, there was no significant difference in the risk of acute myocardial infarct among users of different types of oral contraceptives according to progestagen type. And, finally, adjustment for relevant confounders in the multivariate analysis increased the risk of the older "2nd generation" pills (with levonorgestrel) and decreased the risk of the newer "3rd generation" pills (with desogestrel or gestodene), suggesting a differential prescription of older and newer pills to women at an anticipated increased risk of thrombotic diseases.

At the same time, with recognition that epidemiological studies are the strongest instrument to assess risks and benefits of different types of drugs, the new study also illustrates that observational studies (which for good reasons and in contrast with clinical trials are not randomised) are very sensitive to different kind of bias; recall bias and selection bias being the most important potential biases to account for. In the MICA study the risk ratio between 3rd and 2nd generation oral contraceptives was 1.14 on the basis of records from general practitioners but 1.74 (70% higher) when the estimate was based on the women's recall, suggesting that some kind of recall bias was present, despite relevant measures taken to diminish it.

The influence of selection of patients and controls in epidemiological case-control studies is illustrated by the different measures of risk of thrombotic diseases

reached in different studies, even in the same region during about the same period. The WHO multicentre study (198 cases) found a fivefold increased risk of acute myocardial infarction in current users of oral contraceptives in Europe but an increase of only 2.6-fold in women who had their blood pressure checked before prescription.¹ The transnational study (140 cases) found a threefold increased risk in current users compared with hospital controls but a twofold risk compared with community controls and compared with users of oral contraceptives with 3rd generation progestogens, implying significantly less risk than for those oral contraceptives with 2nd generation progestogens.²

An important challenge to the investigators of epidemiological studies is to take relevant consideration of such biases and to try to assess the possible impact of these methodological circumstances. This attempt is the first opportunity for the lay press to effect a balanced message to the public and for health authorities not to overreact to new publications on rare side effects of oral contraceptives. Thereby unnecessary new pill scares may be prevented. Unfortunately, reassuring studies, such as the MICA study, are usually the object of less attention than they deserve.

1 World Health Organisation. Collaborative study on cardiovascular disease and steroid hormone contraception. Acute myocardial infarction and combined oral contraceptives: results of an international multicentre case-control study. *Lancet* 1997;349:1202-9.

2 Lewis M, Heinemann LAJ, Spitzer WO, MacRae KD, Bruppacher R. The use of oral contraceptives and the occurrence of acute myocardial infarction in young women. *Contraception* 1997;56:129-40.

Corrections and clarifications

Quebec faces severe pressure on casualty departments

In this news article by David Spurgeon (27 February, p 556) the value of Canadian dollars was wrongly converted: \$C20m is roughly equivalent to £8m and \$US12m (not £48m and \$77m).

Call to needle times after acute myocardial infarction

Because of an editorial oversight, the letters by June Edhouse and colleagues and Matthew Hough and John Knighton (27 February, p 597) referred to patients being "thrombolysed" and "the opportunity to thrombolysed patients." These should, of course, have been changed to patients being "treated with thrombolytic drugs" and "the opportunity to provide thrombolytic treatment."

Reforming British primary care (again)

This editorial by Trish Groves (20 March, pp 747-8) wrongly stated that primary care groups will not commission mental health services. The NHS Executive's *Health Service Circular HSC 1998/198* makes clear that primary care groups will commission most mental health services—excluding the high cost, low volume specialised services such as psychotherapies and forensic services—for adults, children, adolescents, and elderly people and drug and alcohol services.

Ordeals for the fetal programming hypothesis

The subtitle of this editorial by Mervyn Susser and Bruce Levin (3 April, pp 885-6) should have read: "The hypothesis barely survives one ordeal but not another" rather than "The hypothesis largely survives one ordeal but not another."

Preventing injuries in children: cluster randomised controlled trial in primary care

This general practice paper by Denise Kendrick and colleagues (10 April, pp 980-3) contains three errors. The calculation of sample size was based on "a mean cluster size of 60 [not 60%]" (first sentence, p 981); in table 3 (p 982) the number of children who received advice at the 18-24 month check should have been 535 rather than 35; and in table 4 (p 982) the number of children in the control group who had any medically attended injury should have been 330 rather than 220.

Computer support for determining drug dose: systematic review and meta-analysis

In this information in practice paper by Robert Walton and colleagues (10 April, pp 984-90) the table stated, correctly, that computer support for control of ventricular arrhythmia with lignocaine led to increased infusion rate in the first hour (p 987). However, the units of infusion rate should have been µg/kg/min (not mg/kg/min, as stated).

ABC of labour care: induction

This article by Geoffrey Chamberlain and Luke Zander (10 April, pp 995-8) includes a diagram titled "Inserting prostaglandin gel into upper vagina" (p 997). In fact, the diagram shows the gel being incorrectly inserted into the upper endocervical canal, next to the fetal membranes. Such a mistake usually causes a hypertonic uterine contraction, which may produce fetal distress and other complications.