expertise not always available in emergency operations.

There is one small group in which vagotomy and pyloroplasty, or gastroenterostomy, is definitely indicated—namely, those patients who have already been fully assessed before they perforate; indeed, they may already be on the waiting-list for definitive surgery. In other cases simple suture or conservative treatment will tide the patient over the immediate crisis. A full assessment of each patient with gastric secretion studies can then be carried out at leisure, only about one-half of all cases ultimately proceeding to definitive surgery.—I am, etc.,

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REFERENCE

- ¹ Kay, A. W., *Hosp. Med.*, 1968, 2, 1418.

Registration of Nurseries and Child Minders

SIR,—In the recent leading article on looking after children (19 October, p. 136) reference was made to the lack of definition of “a substantial part of the day” in the Nurseries and Child Minders Regulations Act, 1948. However, the situation has now been clarified by Section 60 of the Health Service and Public Health Act, 1968, which amends the earlier Act by substituting a period of two hours in the day (or an aggregate of two hours) in place of a substantial part of the day. Certain other changes have also been introduced, and, in particular, attention is drawn to the deletion of the former provision in the 1948 Act that an offence is only committed when the number of children taken in exceeds two and the children come from more than one household.

Section 60 of the 1968 Act came into force on 1 November and consequently from that date the scope of the 1948 Act was extended to include premises (other than those used wholly or mainly as private dwellings) in which children are received for a total of two hours or more in the day and persons who, in their own homes and for reward, look after one or more children under the age of 5 years, to whom they are not related, for similar periods.¹ It will be an offence to accommodate children in these circumstances without registration or to fail to comply with the requirements of the local authority following the expiry of a three-month period of grace, and the maximum penalties have been increased substantially.

Many medical officers in the preventive field will have encountered cases of children whose needs, other than the purely physical, have been grossly neglected by child minders with disastrous consequences, and so the increased control of such activities is welcomed. There has been a remarkable expansion in the registration of nurseries and child minders in recent years, and by and large these provide a useful social service, even though early placement of children may be deplored unless there are good grounds for it.

It is unrealistic to expect much extension of local authority day-nursery provision at the present time, except possibly in the priority areas in view of financial stringencies, and so we must continue to look to the private sector

to meet the need, but with proper safeguards.—I am, etc.,

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REFERENCE

- ¹ Ministry of Health circular 36/68, Amendments to Nurseries and Child Minders Regulation Act 1948, 1968. London.

Puerperal Thromboembolism

SIR,—Professor T. N. A. Jeffcoate and his colleagues (5 October, p. 19) and also the leading article on puerperal thromboembolism (5 October, p. 1), make a number of statements on which we wish to comment.

We showed¹ that factor IX levels were increased in puerperal patients on stilboestrol, but did not claim that “diethylstilboestrol increases the coagulability of blood by raising the level of factor IX.” There is no firm evidence that increased factor IX levels in fact render blood hypercoagulable.

The comment in the leading article, “At Cardiff the increase in puerperal thromboembolism imputed to oestrogen suppression of lactation was more than double that reported from Liverpool . . .” is inaccurate. The overall incidence in Liverpool is 1.0/1,000 in breast feeders and 3.4/1,000 in suppressed patients; a ratio of 3.4 or an arithmetic difference of 2.4. The comparable figures for Cardiff² are 2.3/1,000 in breast feeders and 5.9/1,000 in suppressed patients; a ratio of 2.6 or an arithmetic difference of 3.6. Similarly these figures do not warrant the comment, “The difference between the two groups of patients is not so great in our

deliveries at Liverpool Maternity Hospital and nine years’ deliveries at Mill Road, which yielded 641 control cases. In some of their subdivisions they have fewer than 10 control cases, and hence their rates are subject to a relatively large sampling error. It is inaccurate to state, “Our series [Liverpool], unlike that published by Daniel *et al.* (1967), indicates that the mode of delivery is very significantly associated with puerperal deep venous thrombosis and embolism” (our italics). We state twice,² and the Table illustrates the point, that operative delivery does increase the risk of thromboembolism. The Table gives the comparable figures for the two cities, and shows that the effect of assisted delivery in the two series are similar in nature.

The leading article in stating, “Indeed the Liverpool analysis suggests that increasing age and major operative intervention at delivery are at least as important as the hormonal suppression of lactation in increasing the chances of thromboembolism,” while discussing differences between the Liverpool and Cardiff findings, implies that the Cardiff figures did not consider age to be relevant. If this is in fact implied, it is grossly inaccurate, as our original article shows.² A similar implication is made in the Liverpool paper in “Discussion.”

We conclude that the Liverpool and Cardiff figures are broadly in agreement with respect to age, method of delivery, parity, and suppression of lactation, and submit that neither series is large enough to enable conclusions to be drawn on which single factor is the most important. It is worth considering, however, that while nothing can be done in the puerperium about a patient’s age, parity, stature, or mode of delivery the

Incidence of Puerperal Thromboembolism per 1,000 Deliveries

	Para 1		Para 2 and 3		Para 3 and Over		All Parities	
	Normal Delivery	Assisted Delivery	Normal Delivery	Assisted Delivery	Normal Delivery	Assisted Delivery	Normal Delivery	Assisted Delivery
Liverpool	1.1	2.8	1.1	3.8	1.9	8.0	1.3	3.4
Cardiff	3.3	4.6	3.4	9.8	7.4	22.9	4.3	8.2
Ratio*								
Liverpool	2.6		3.5		4.2		2.6	
Cardiff	1.4		2.9		3.2		1.9	
Arithmetic differences†								
Liverpool	1.7		2.7		6.1		2.1	
Cardiff	1.3		6.4		15.5		3.9	

* Ratio = Incidence of thromboembolism in assisted deliveries.

Incidence of thromboembolism in normal deliveries.

† Arithmetic differences = Incidence in assisted deliveries minus incidence in normal deliveries.

(Liverpool) series as was reported from Cardiff.” We believe that the ratio is more important as a measure of relative risk between two groups than the arithmetic difference, as the latter depends on the absolute level of case finding in a population, which in turn depends on the medical practice in that region. The ratio of incidences between two groups within a region is not dependent on local medical practice. Therefore the ratio may be more meaningful when comparing relative incidences between different regions. Thus Liverpool found a higher ratio in the incidence of cases of thromboembolism found in suppressed mothers compared with the breast-feeding mothers.

It is not surprising that in the smaller subdivisions differences in magnitude are seen between the two cities. The Cardiff figures² are based on 9,324 deliveries, but the rates in the smaller groups are based on fewer than 500 control cases. The Liverpool figures are based on a 1% sample of 11 years’

giving of hormones to suppress lactation is wholly within the doctor’s control. Moreover, it is not a simple choice between giving or withholding hormones for suppression of lactation. Perhaps we should be returning to the third alternative, breast feeding, as a possible way of reducing maternal mortality.—We are, etc.,

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² Daniel, D. G., Campbell, H., and Turnbull, A. L., *Lancet*, 1967, 2, 287.