abortion is less than that found at full-term delivery, and hence the risk of sensitization associated with abortion should also be less. —Ed., *B.M.J.*

Oral Contraceptives Containing Oestrogens

SIR,—A preliminary communication from the Committee on Safety of Drugs has just been sent to all doctors in the United Kingdom. The text is as follows:

"Approximately half the oral contraceptives prescribed in the United Kingdom contain 75 µg. or more of oestrogen in the form of either mestranol or ethinyloestradiol; the remainder contain only 50 µg.

"Reports of suspected adverse reactions received by the Committee on Safety of Drugs now provide evidence that the incidence of thromboembolism is higher among women taking preparations containing larger doses of oestrogen than among those taking preparations containing the smaller dose.

"The Committee has no evidence that oral contraceptives containing 50 µg. of oestrogen are less effective than the others and recommends that oral contraceptives containing the smaller dose of oestrogen should normally be prescribed."

The Committee has no evidence on which to base any advice about the incidence of thromboembolism during the use of any oral contraceptive containing progestogen alone.

The relation between the use of oral contraceptives and thromboembolism has been well established, but the Committee is of the opinion that the risk of this complication is less with the lower oestrogen dose.

The Committee is not suggesting that any of these preparations should not be available for the treatment of gynaecological disorders, and the early warning refers solely to their use as oral contraceptives.

Arrangements had been made to ensure that the profession was informed before any public announcement was made. Unfortunately premature press publicity necessitated an urgent public announcement in order to allay undue anxiety and to allow of informed press comment. The Committee regrets that this should have been necessary and apologizes to the profession as a whole that events have occurred in this inappropriate order through no fault of its own.

None of the work which has been undertaken would have been possible without the help of a large number of the profession, and the Committee is very grateful for that collaboration. It would, however, urge an increased vigilance on the profession as a whole in relation to adverse reactions from contraceptive medication and asks that the Committee should be informed at the earliest opportunity of all adverse reactions. It is only by this full collaboration that drug safety problems can be identified and early warnings given.—I am, etc.,

E. F. SCOWEN,
Chairman,

London S.W.1. Committee on Safety of Drugs.

Value of Osteopathy

SIR,—Dr. D. A. H. Yates in his review of a *Manual of Osteopathic Practice* (6 December, p. 610) mentions some errors in medical aspects that will make the ordinary medical reader question the veracity of other statements in the book.

One such error, according to Dr. Yates, is the statement that "the distinction between osteoporosis and osteomalacia in adults is that in the latter condition the bones become soft rather than brittle, and become misshapen rather than fractured." I am not concerned with osteopathy, but, nevertheless, cannot accept criticism of this statement. I am sure that all who are interested in metabolic bone disease will agree with me that Dr. Stoddard, the author, correctly differentiates osteoporosis and osteomalacia.—I am, etc.,

Solihull, Warwicks.

PHILIP JACOBS.

SIR,—Dr. D. A. H. Yates in his review of my *Manual of Osteopathic Practice* (6 December, p. 610) has pointed out an error of dosage of vitamin D, which should have read 5,000 units instead of 50,000 units. I am sorry that this typographical error, which will be corrected post-haste in all unsold copies, should have given Dr. Yates an excuse for being critical of my statements generally.

He is sceptical of my claim that discrepancies of $\frac{1}{4}$ in. (6 mm.) at the iliac crests can be detected clinically, and that a degree of loss of mobility can be palpated in the movements of the thoracic spine. I make no excuse for these statements, because anyone who is willing to take the trouble to examine the spine with care and attention to detail can observe these points. The methods of examination and treatment indicated in the book are all within the compass of any medical practitioner, but he will need much practice to become adept.

I see no criticism or praise for that matter for the general theme of my book, which is a presentation of osteopathic ideas in the assessment and management of spinal problems. My objective was to act as an interpreter of the osteopathic point of view written in an acceptable form for the medical world at large, and I hope I have succeeded in this.—I am, etc.,

London N.W.1.

ALAN STODDARD.

Tracheal Intubation

SIR,—I was glad to see that Dr. P. H. Beves (6 December, p. 619) has drawn attention to the fallacy of over-extension of the head when performing tracheal intubation.

Some first-aid manuals have illustrations of unconscious victims with a large rolled-up rug under their shoulders and with their heads forced back so far that the occiput is pressed against the upper thoracic spine. This is supposed to be the position of choice for mouth-to-mouth respiration. It is noticeable that this absurd posture is always shown in diagrammatic form and never reproduced from a photograph, the reason being that no conscious model would tolerate it for more than a few seconds. I would suggest that the artists concerned might try it themselves.

Exaggerated hyperextension of the head actually causes respiratory obstruction, as the tightly stretched skin of the neck forces the larynx and trachea back against the convexity of the cervical spine.—I am, etc.,

London N.6.

C. LANGTON HEWER.

Feto-maternal Bleeding and Hypertension in Pregnancy

SIR,—Dr. P. Jones and his colleagues (27 September, p. 738) are to be congratulated on their study of the connexion between rhesus sensitization and toxæmia. Both conditions are, in my view, rejection phenomena: the first revealing intolerance to excessive influx of foreign fetal cells, the second intolerance to excessive influx and activity of foreign fetal (or hydatidiform) hormones. This theory¹ may have been overlooked, but its ability to explain the facts has not, to my knowledge, been challenged, and its basis has recently been confirmed. That basis was the finding² that a significant majority of boys were born to eclamptic primiparae, but not to eclamptic multiparae. Professor Neville Butler and Dr. E. D. Alberman³ have found, in further study of the 1958 perinatal survey, that the male:female ratio increased from 1.05 to 1.09, 1.11, and 1.19 respectively among the offspring of mothers (the majority primiparae) with no, mild, moderate, and severe pre-eclampsia.

In the absence of toxæmia, resistance to (stimulation by) fetal hormones is shown by a sudden, sustained slowing of maternal weight increase after the seventh month—that is, when the baby is growing fastest. Thus, the approximate gains reported by Cummings⁴ from the third to the ninth months were: 1½, 3½, 4½, 4½, 5½, 3, and 2 pounds (0.75, 1.75, 2.25, 2.25, 2.75, 1.5, and 1 kg.) per month. Multiparae with residual resistance can consume an excessive diet with comparative immunity; but until they have acquired resistance toxæmia-prone primiparae are vulnerable, and unable to cope adequately with the combination of an excessive carbohydrate diet plus heavy hormone influx—for example, with twins, a large baby, or hydatidiform mole—particularly when the foreign hormones are produced by a male fetus.

A rise of diastolic pressure is held by Dr. Jones and his colleagues to mark the onset of toxæmia, and this is the orthodox view. But in toxæmic primiparae it is incorrect. In these Hamlin⁵ noted the diastolic rise at the 34th week, three weeks after marked digital oedema (which he called prehypertensive pre-eclampsia); and preceding the latter were 10 weeks of excessive, dietetically preventable gains of weight. The early warning sign, digital oedema, in primiparae is sex linked like eclampsia.⁶ Dr. Jones observed significant increases of fetal cells in the 32nd and 33rd weeks—the pre-hypertensive period. These increases were indicative of placental breaks, and support the thesis that placental damage results from maternal reaction to foreign hormone entry. The rise of diastolic pressure, indicating vasospasm, reveals reduction of placental blood-flow, with consequent reductions both of fetal hormones and fetal cells entering the maternal circulation. This reverse finding was noted by Dr. Jones.

To prevent rhesus sensitization, prevention of toxæmia (by correct diet) is a first essential. Also it seems wise to give anti-D gammaglobulin when fetal cells are passing in abnormally large numbers—that is, when there is marked digital oedema—whether accompanied or unaccompanied by oedema of the abdominal wall. Such oedema should not, however, be accompanied by a high diastolic rise—for example, over 100 mm.