Correspondence

Contraceptive Failure Rates

Str,—In your leading article (6 May, p. 537) you comment ( apropos the M.R.C. pill report on oral contraceptives) that "it is generally accepted that the overall failure rate of other methods of contraception is about 10% per woman year, and it might be estimated therefore that about 80,000 of these women would have become pregnant." The use-effectiveness of contraceptive methods is usually expressed in terms of pregnancies per 100 woman years of exposure, and on this basis the failure rates of traditional forms of contraception vary from 2.0 to 3.5 for the condom and I.U.D.1 to 12.5 to 14.62 for the diaphragm and chemical spermicides. On this basis very few of the 800,000 women would have become pregnant during the single year. —I am, etc.,

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John Peel

REFERENCES


Preventing Pressure Sores

Str,—Dr. Mary Bliss (18 March, p. 697) states that in her experience established infection does not occur in pressure sores. This conclusion is contrary to the findings at the Liverpool Regional Paraplegic Centre. Patients admitted with sores being either totally or partially anaesthetic over the whole body are unable to volunteer statements as to whether the sores are painful or throbbing. It is consequently necessary to pay attention to the systemic effects of infection. These are loss of appetite, apathy, and toxic conduction and psychotic states due to absorption of pus from the pressure sores. Laboratory investigations reveal a persistent anaemia, leucocytosis, and a depression of the serum albumin, sometimes with elevation of the serum globulin. When the sores have healed the general signs of infection disappear, the patient's morale, appetite, and haemoglobin improve, but it often takes a considerable time.

It would seem on reading the original article (18 February, p. 323) that Dr. Mary Bliss made a fundamental error in her calculations, for she states, "that recovery of the sores with treatment was associated not only in the patient's sense of well being, but often with apparently real improvement in the patient's general condition also." Further confirmation of the severe systemic effects of pressure sores may be obtained by studying Dr. Tribe's observations1 on 150 necropsies performed on paraplegic patients at Stoke Mandeville Hospital. Forty-eight of these patients had severe amyloidosis of their kidneys, and this was largely attributable to chronic pressure sores with underlying bony infection.

Unfortunately no sore will heal while there is persistent pressure, removal of the pressure alone will not heal all bedsores. Some of the factors that prevent sores healing despite removal of pressure have been enumerated by Guttmann. These factors include underlying osteomyelitis, superimposed pressure due to spasm, and poor general condition of the patient.

A sore at the greater trochanter with severe underlying osteomyelitis is a particularly difficult problem, since the infection may track and involve the pelvis. Plastic surgery has little to offer when there is such infection, and such a sore is best treated by an orthopaedic surgeon, since an extensive dissection of the hip and the upper one-third of the femoral neck is involved.

Antibiotics have been found to be of value in the treatment of pressure sores at two distinct stages of their treatment. Initially on admission when the patient is toxic and febrile he is placed upon a combination of cloxacillin and ampicillin. While the surgeon carries out the debridement of the sore and opens up all the closed pockets of infection, the use of systemic antibiotics localised to the patient's blood is used when a patient with valvular disease of the heart has a dental extraction. At a later stage when grafts are applied to a granulating area the sensitivity of the organism in the sores is first determined prior to grafting and then the combination of systemic and local antibiotics appears to facilitate the take of the grafts, since some organisms, particularly the staphylococcus, are particularly liable to destroy skin flaps.

The best way of reducing cross-infection and preventing the emergence of resistant organisms is controversial, but it is undeniable that preventing pressure sores occurring and healing as expeditiously as possible those that do occur is a step in the right direction.

—I am, etc.,

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J. R. Silver

REFERENCES


Illicit Vein Compression

Str,—In their paper (1 April, p. 14) on 57 patients with illo-femoral thrombosis, over half of whom also had varicose veins, Mr. F. B. Cockett and his colleagues state that "the main pathological factor in these cases is shown to be a compression stenosis of the left common iliac vein by the overriding right common iliac artery."

I suggest the central weakness in this contention is that it implies the body adjusts to the narrowing produced by the iliac artery, and that it does not account for the rarity of these venous conditions in peoples still living primitively. I have an alternative view, which is carefully developed elsewhere,1 and have pointed out that these venous troubles, and their preponderance in the left leg, are related to a colonic cause. It is unfortunate that in 24 references the authors do not include a single one showing the rarity of these venous complaints in peoples still subsisting on an unrefined diet, as in the native reserves of South Africa, though such complaints readily occur in them directly they move on to sophisticated foods. It is indeed a tragedy if the remarkable figure of one in 20,000 from these reserves2 are so little known and appreciated in this country.

It is easy to see how the iliac artery might exert some influence on a distended thrombosed iliac vein, limiting the spread of a thrombosis from below, but this is very different from its exerting any influence on a healthy vein, and still less from its being the cause of an original thrombosis. The authors note that 18.5% of their post-thrombotic obstructions were localized in the region

chloroquine

Correspondence

Chloasma and the Contraceptive Pill

Str,—With increasing frequency in the use of contraceptive pills there is, as would be expected, an ever-increasing list of side-effects reported, which includes breakthrough, gastrointestinal symptoms such as nausea and vomiting, change in menstrual flow, change in libido, reduction in frequency and severity of dysmenorrhea, weight gain, breast tenderness, headaches and dizziness, depression, leg pains and cramps, fatigue, nervousness, hirsutism, amenorrhoea, jaundice, moniliasis, chorea, and thromboembolic disorders.

To this list has recently been added adenoma of the breast and chloasma. Very little reference is made to chloasma alone as a frequent complication. One survey involving 263 patients who had used contraceptive pills for a period of three months to six months, showed that 1.2% of cases had developed chloasma. It is clear that this effect was more frequent in certain patients with a pigmented skin, and that the use of contraceptives may accentuate the chloasma passed on by heredity. All patients with these develop very marked chloasma and appear to be more susceptible to the effects of contraceptive pills.

To my knowledge this is the first time that this condition has been reported. It may not be caused by the contraceptive pill alone, but may be accentuated by it. It is to be noted that this condition has been seen in women using different brands of contraceptives, and is not confined to contraceptive pills alone. It is possible that other factors may be responsible for this condition.


REFERENCES


References