reported, although about 20,000 patients have now been treated, many of them during pregnancy. In the past we have treated patients who have been taking oral contraceptives, but we do not now feel that it is prudent to do so in the future.

Hugh O. Jones, Julian C. F. Townsend.
Varicose Vein Clinic, J. T. Roberts.
Institute of Pathology, Cardiff Royal Infirmary, Cardiff.

Chloasma and the Contraceptive Pill

Sir,—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 bleeding, 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 through 2,664 cycles of taking contraceptive pills reported only one patient—that is, 0.5%—with this condition. I have, however, seen six such cases in my practice in the three-month period August to October 1966, and suggest that this complication of contraceptive pills occurs more frequently than is generally appreciated.

All six patients were Caucasians permanently resident in the Tropics. Three of the six cases had recurrent chloasma uterinum, which cleared after delivery, except on the last occasion, when the pill method of contraception was commenced, and the pigmentation in each case then deepened. In the other three, pigmentation appeared at the first instance three to four years after the pill was taken.

In three cases where the pill was abandoned, lightening of the chloasma become significant and progressive over this three-month period. No different effect was noticed in the six cases between one contraceptive pill and the other. With a larger selection of patients using different products one might be able to determine which products cause chloasma more readily, and from some opinion as to whether the progesterone or the oestrogen is the culpable hormone.

Armed with this knowledge, the doctor is then in a position to prescribe to his susceptible patients that combination least likely to promote this particular side-effect.

I am grateful to the Ministry of Health, Trinidad and Tobago, for permission to publish this letter.

I am, etc.,
David B. E. Quamina.

REFERENCES

Contraceptive Failure Rates

Sir,—In your leading article (6 May, p. 127) you comment ( apropos of the M.R.C. report on oral contraception) 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 been the findings.”

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 vary from 2.0 to 3.5 for the condom and I.U.D.1 to 12.5 to 14.6 for the diaphragm and chemical spermicides. On this basis very few of the 800,000 women would have become pregnant during a single year.-I am, etc.,

Department of Sociology, University of Hull.

REFERENCES

Preventing Pressure Sores

Sir,—Dr. Mary Bliss (18 March, p. 697) states that in her experience established infection does not occur in pressure sores. This 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 constitutional and psychic 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. 690) that Dr. Mary Bliss made the same observations, since 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 observations 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 while 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 Buttman. These are, underlying osteomyelitis, healing of ulcers 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 femur is involved.

Antibiotics have been found to be of value in the treatment of pressure sores at two different stages of their treatment. Initially on admission when the patient is too weak 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 is continued. The combination of tepid and ampicillin 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 organisms in the sore 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 pressure sores is a step in the right direction.-I am, etc.,

Southport.
J. R. Silver.

REFERENCES

Iliac Vein Compression

Sir,—In their paper (1 April, p. 14) on 57 patients with ilio-femoral thrombosis, over half of whom also had varicose veins, Mr. F. B. Cockett and his colleagues state that “the main aetiological 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 is unable to move, and it does not account for the rarity of these venous conditions in peoples still living primatively. 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 surviving 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 of female reproductive age to come from these reserves3 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.

References