Intracranial Venous Thrombosis and the Pill

SIR,—I was surprised to see only the progesterone component of two oral contraceptives mentioned in an article on cerebral thrombosis attributed to their use (16 June, p. 647).

Both contraceptive pills contain oestrogen as well: mestranol 0·1 mg in Ortho-Novin, and ethinylestradiol 0·05 mg in Minovlar. So far as I know, no episodes of thrombosis have been reported as due to progesterone-only contraceptives. On the other hand, oestrogens are known to affect several blood clotting factors, and the increased incidence of thromboembolic disease in women taking combined preparations is accepted as due to the oestrogen component.—I am, etc.,

P. N. HOLBERTON
Kempsey, N.S.W., Australia

Smoking Hazards to the Fetus

SIR,—Space does not permit a full analysis of the letter from Dr. R. I. Hickey and his colleagues (1 September, p. 501) in which they focus on the role of possible causative factors influencing the well-known statistical association between maternal cigarette smoking in pregnancy and birth weight.

We are concerned, however, that they cite our work only to dismiss it as in "error." We did not, in fact, make the elementary error of suggesting that an association by itself proves a causal relationship; nor, so far as we are aware, do other reports in the literature. We did in fact suggest that it might be possible to test the causal hypothesis by a controlled trial in which women were persuaded to give up smoking during pregnancy.

Dr. Hickey and his colleagues appear to dismiss a causal relationship because not all babies of smokers are of low birth weight. Is this really what they imply? The "alternative" hypothesis which Yerushalmi² is purported to have tested (namely, that babies born to women before they become smokers will be lighter than those of non-smokers) suffers from severe methodological shortcomings,¹ making it clearly untenable. We would, however, agree with them that the "causal" question is still not settled, but we feel that it would be unfortunate if the progress so far made in discouraging mothers from smoking in pregnancy were to be interpreted by the kind of arguments used in their letter.—We are, etc.,

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Doctors in South Africa

SIR,—Apparently Mr. I. N. Bernadt (22 September, p. 632) reads only the advertisement pages of the South African Medical Journal, otherwise he would know that the Medical Association of South Africa has done considerably more than utter verbal condemnation of racial discrimination in the medical field. It has repeatedly sent deputations to the patients and the public to protest against the abolition of discrimination in salaries, resulting at one stage in an (admittedly only slight) improvement. Over a year ago in its journal it publicised the establishment of a Salary Equalisation Fund for the receipt of voluntary contributions from non-African doctors towards supplementing the official salaries of their African colleagues. (I hope the fund will receive many contributions as a result of Dr. Bernadt's letter.)

The fact that coloured doctors cannot, in South Africa, examine white patients is not due to the attitude of the medical profession in that country or even to the Government, as Dr. Bernadt surely must know. With rare exceptions, white persons would refuse generally with vehemence—to be examined by non-white doctors; and even if they agreed, white nurses in attendance upon them would refuse to assist in such examinations, generally with no less vehemence and with the support of every member of parliament (government and opposition), except perhaps one, the vast majority of their white nursing colleagues, and South African Whites as a whole. These attitudes of white patients and nurses long antedate 1948, the year in which the present political rulers of South Africa came first to power.—I am, etc.,

G. W. GALE
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Alcoholism and the G.F.P.

SIR,—In view of the considerable publicity and controversy associated with the "Helping Hand" report on this matter¹ I would be grateful for an opportunity to identify my position. In the lecture of mine quoted in the report I said: "Studies suggest the general practitioner is frequently not an effective agent for picking up alcoholics. The reasons would appear to be two-fold. Firstly, the patient's distress is not sufficiently compelling to bring this problem to the doctor. Secondly, the general practitioner is likely to miss cases of alcoholism if his stereotype of the alcoholic is of a skid row figure—that is, the end state of the disease becomes the only form recognized and his lack of awareness that in the early stages alcoholism presents with primarily social, rather than medical pathology."²

R. Bernadt
Delagay, Co. Wicklow, Eire


2 Shake Test on Amniotic Fluid and the Respiratory Distress Syndrome

SIR,—I wish to comment on the suggestion of Dr. P. M. Fisher and others (19 May, p. 423) that, for assessing fetal pulmonary maturity and the risk of neonatal respiratory distress syndrome, a critical amniotic fluid lecithin concentration of 3·5 mg/100 ml is too low. Their suggestion is based on the evidence of pulmonary hypoperfusion in two newborn infants with predelivery amniotic fluid lecithin levels of 5·70 and 7·35 mg/100 ml respectively and a negative bubble stability test though the infants had no respira-