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Because we receive many more letters than we have room to publish we may shorten those that we do publish to allow readers as wide a selection as possible. In particular, when we receive several letters on the same topic we reserve the right to abridge individual letters. Our usual policy is to reserve our correspondence columns for letters commenting on issues discussed recently (within six weeks) in the BMJ.

Letters critical of a paper may be sent to the authors of the paper so that their reply may appear in the same issue. We may also forward letters that we decide not to publish to the authors of the paper on which they comment.

Letters should not exceed 400 words and should be typed double spaced and signed by all authors, who should include their main degree.

Doctors and the drug industry

SIR,—The report from the Royal College of Physicians on the relationship between the medical profession and the pharmaceutical industry (Dr Richard Smith, 11 October, p 905) sets out a code of practice that will be welcomed by those doctors who feel uncomfortable about accepting financial support for research from the industry. It is also particularly appropriate that we should examine our relationship at a time when lack of government support for research has forced us to look elsewhere for funds to perform and present scientific work.

The college report cites examples of doctors accepting travelling expenses to foreign scientific meetings and condemns this practice but does not convey the impression that it is widespread. On the contrary, we believe that many important European meetings in our own specialty (and presumably others) are largely supported covertly through the pharmaceutical industry by the sponsorship of attending delegates and the payment of large registration fees up to as much as £300. We also believe that neither the pharmaceutical industry nor the sponsored delegate can be blamed entirely for this trend, which we think is one of the factors which threaten the continued development of high quality scientific research in Britain.

In any specialty there is each year an increasing number of conferences which an active research worker can attend to present his work—perhaps two or three in the United Kingdom, one in Europe, and one in North America. Since most doctors have clinical commitments and do not have an inexhaustible supply of presentable research they must choose which conferences to attend. It is not surprising therefore that the beleaguered senior

research worker or delegate health service consultant will choose the more exotic location and accept the hospitality proffered by the pharmaceutical industry. The junior research worker, however, or consultant with scruples about accepting sponsorship cannot attend these meetings since the personal expense is too great and attends instead the meetings in his or her own country.

International meetings are extremely important for disseminating scientific information, but they need not be extravagantly expensive beyond the cost of travel and accommodation. They could, like many British meetings, be held in universities rather than conference centres, while the number of invited speakers and the quality of entertainment should be influenced by the revenue rather than determining the registration fee. British meetings like those of the Medical Research Society and the British Thoracic Society have an increasing record for scientific quality without expense and deserve to be well supported. Expensive foreign meetings encourage poor quality "meal ticket" abstracts, inflated registration fees, and absenteeism from home meetings. There is even a danger that the direction of research may be influenced by the attraction of forthcoming meetings.

We do not, however, want to discourage involvement in scientific meetings by the pharmaceutical industry if that is what it wants, but we would ask our British colleagues who help to organise international meetings to remember that they have a responsibility not to make the meetings exclusive to those who can raise sponsorship; it is better to use the money openly to reduce registration fees or provide travel scholarships. If drug company money is available for support of scientific

conventions then it should be spent on the meeting and not on hospitality for those in favour with the industry.

M D L MORGAN

Department of Respiratory Medicine,
East Birmingham Hospital,
Birmingham B9 5ST

A BUSH

Lung Function Department,
Brompton Hospital,
London SW3

The pill and breast cancer: why the uncertainty?

SIR,—Messrs Klim McPherson and James Owen Drife discussed possible reasons for the apparent discrepancies between recent studies and called for further information from them (20 September, p 710). They suggested that the reasons might include geographical differences in the rate at which oral contraceptives came to be widely used. If, as they suggested, the greatest hazard was likely to be seen in women who used the pill before their first pregnancy and the effect occurred only after a latent period of some 15 years, an increased risk might now be found only in those countries in which the use of oral contraceptives by young women first became common.

In support of this suggestion it has been claimed that the lack of an increased risk in the USA is because the use of oral contraceptives by young women became common in that country about five years later than in Britain.¹ No such difference can, however, account for the failure to find an increased risk in New Zealand. Analyses which we

Oral contraceptive use (%) in nulliparous women, or before first term pregnancy in parous women, in New Zealand. Figures in parentheses are equivalent percentages for British women*

Use before first pregnancy	Year of birth						
	Before 1930	1930-4	1935-9	1940-4	1945-9	1950-4	1955-9
Never	100 (99)	95 (97)	90 (94)	70 (86)	34 (59)	38 (43)	18 (27)
< 4 years	0 (1)	4 (3)	10 (5)	25 (12)	48 (29)	36 (43)	52 (27)
≥ 4 years	0 (0)	1 (0)	0 (1)	5 (2)	18 (12)	26 (14)	30 (45)
No of women	14 (621)	158 (646)	187 (498)	190 (268)	156 (154)	108 (48)	83 (11)

* British data from McPherson and Coope.²

have now undertaken provide evidence of the prevalence of use in New Zealand compared with that in Britain (table). In both countries the data were obtained in exactly the same way, using the information provided by control subjects in large case-control studies.^{2,3} Clearly, use of the pill before the first pregnancy has been more extensive and began earlier in New Zealand than in Britain.

Messrs McPherson and Drife also suggested that the usual analysis of relative risks by time since the first use of oral contraceptives, as presented in our paper (20 September, p 723), might not be sufficient to show a latent effect. We have reanalysed our data using the method recommended by McPherson *et al*; this involves successive calculations of relative risks excluding exposure within increasingly long periods before the date of diagnosis (or the corresponding date for controls).³ The relative risks associated with the use of oral contraceptives for four years or longer before the first full term pregnancy (relative to never users in that period) were 0.60 (95% confidence interval 0.33-1.1) considering all such use up to the time of diagnosis, 0.65 (0.35-1.2) excluding such use within five years of diagnosis, 0.44 (0.19-1.0) excluding such use within 10 years of diagnosis, and 0.43 (0.08-2.1) excluding such use within 15 years of diagnosis. These relative risks were adjusted by logistic regression for age, age at menarche, age at first full term pregnancy, history of benign breast disease, family history of breast cancer, and ethnic group. There was no hint of a latent adverse effect.

It is still too early to predict whether a latent effect will emerge more than 15 years after prolonged use of the pill at young ages, but latency does not seem to be a plausible explanation for the results of recent studies.

The report from Scandinavia pointed to a possible association of risk with the total duration of pill use and suggested that previous studies might have included insufficient numbers of very long term users.⁴ The proportions of women under 45 who had used oral contraceptives for eight years or longer were 17% in Sweden and 9% in Norway. Long term use has been even commoner in New Zealand: 22% of our controls under 45 had used the pill for eight years or longer. Moreover, oral contraceptive use almost certainly became common earlier in New Zealand than in Scandinavia. In January 1965 there were more women using oral contraceptives in Australia and New Zealand than in the whole of Europe (excluding the UK);⁵ by 1966 20% of women of reproductive age in these countries were estimated to be using the pill (compared with 8% in the USA and 3% in the UK).⁶ Oral contraceptives were not introduced in Sweden and Norway until 1964 and 1967 respectively.⁵

We strongly support the call in your leading article for further collaboration among the investigators in the various studies. Several important questions need to be addressed, including the types of pill used in different countries and the effects of use at very young ages (close to the

menarche). We have an open mind on such issues, and indeed our study in New Zealand is continuing. For the present, however, we see no reasons to revise the conclusions in our report.

CHARLOTTE PAUL
D C G SKEGG
G F S SPEARS

University of Otago Medical School,
Dunedin, New Zealand

J M KALDOR

International Agency for Research
on Cancer,
Lyon 8, France

- 1 Anonymous. Another look at the pill and breast cancer [Editorial]. *Lancet* 1985;ii:985-7.
- 2 McPherson K, Coope PA. Early oral contraceptive use and breast cancer risk. *Lancet* 1986;i:685-6.
- 3 McPherson K, Coope PA, Vessey MP. Early oral contraceptive use and breast cancer: theoretical effects of latency. *J Epidemiol Community Health* (in press).
- 4 Meirik O, Lund E, Adami H-O, Bergström R, Christoffersen T, Bergsjö P. Oral contraceptive use and breast cancer in young women. *Lancet* 1986;ii:650-4.
- 5 Jones GW, Mauldin WP. Use of oral contraceptives: with special reference to developing countries. *Studies in Family Planning* 1967;No24:1-13.
- 6 Guttmacher AF. The pill around the world. *IPPF Medical Bulletin* 1966;1:1-2.

Prolonged pregnancy: the management debate

SIR,—Dr Linda Cardozo and her coauthors are to be congratulated on attempting to answer a very difficult question (25 October, p 1059). Their conclusion is fully justified—namely, that there is “no evidence to support the view that women with normal prolonged pregnancy should undergo routine induction of labour at 42 weeks gestation” (my italics).

As long ago as 1954 Walker *et al* showed that fetal anoxia occurred in some, but not all, prolonged pregnancies and that this was more likely to occur in primigravidas, especially older ones.¹ Following the publication of the first national perinatal mortality report in 1963² many clinicians concluded that prolonged pregnancy was universally dangerous to the fetus and adopted a policy of routine induction of labour at some stage after the calculated expected date of delivery. This contributed to the very high induction rates prevalent in the early 1970s.

There then followed a consumer led reaction against this and other types of intervention in pregnancy and labour. It is, however, important to ensure that, so far as possible, we can identify the individual fetus that is at risk from prolonged pregnancy and deliver it before it sustains appreciable damage.

The method proposed for checking fetal health by Dr Cardozo and her colleagues is certainly expensive and may be impracticable. It includes cardiotocography on alternate days, so women face the inconvenience and the cost of attending a clinic on alternate days, and much midwife time is spent obtaining the cardiotocography records.

The authors recruited these patients at 290 days' gestation, but they do not describe the categories and numbers of women who had had labour induced—non-routinely—before this. It would be of interest to have this information for in these women prolonged pregnancy was in any case avoided.

The authors state that the active and conservative groups were matched for age, parity, and smoking habits. They should, however, publish the actual age and parity of their patients. If the trial subjects were predominantly young women one would expect fewer problems from prolonged pregnancy, no matter how managed. If, on the other hand, the study included a large proportion of primigravidas and older women the results would be more meaningful.

One of the great difficulties in conducting such a prospective study is illustrated by another chance finding. The active group, by chance, contained women who might have been expected to have done less well in labour. This is because the mean Bishop score in the active group was significantly lower, as was the proportion of women with the fetal head engaged in the pelvis at the onset of labour. These chance but significant differences may themselves explain the slight outcome differences between the two groups.

The report is an important contribution to the debate about the management of prolonged pregnancy. Its main conclusion is justified. It does not, however, prove that prolonged pregnancy is not hazardous to some babies; nor does it yet show a reliable and practicable method for identifying the minority of women in whom prolongation of pregnancy can be hazardous to the fetus.

K JOHN DENNIS

Department of Human Reproduction
and Obstetrics,
Princess Anne Hospital,
Southampton SO9 4HA

- 1 Walker J. Fetal anoxia. *Journal of Obstetrics and Gynaecology of the British Empire* 1954;61:162-6.
- 2 Butler NR, Bonham DG. Perinatal mortality. The first report of the 1958 British perinatal survey under the auspices of the National Birthday Trust Fund. Edinburgh: Livingstone, 1963:304.

AUTHORS' REPLY—Assessment of fetal health antenatally by means of cardiotocography is of uncertain value. We felt, however, that such extra surveillance was necessary for the conservatively managed group as we were going against usual practice. As can be seen from our results only five patients had an abnormal antenatal cardiotocograph and all of these had been recognised as having been at risk because they had late onset intrauterine growth retardation. The necessity of performing cardiotocography is therefore debatable and needs to be properly evaluated. There is also a widespread trend to manage more patients with complications of pregnancy as outpatients. This has resulted in many hospitals setting up cardiotocography clinics (or fetal welfare laboratories). If prolonged pregnancy is managed conservatively the additional workload will amount to only about 6% of the population.

I am afraid that we cannot describe the categories or number of women who were induced before 290 days. At the time the study was conducted the induction rate at King's College Hospital was about 6% and these women were presumably induced because of clinical concern as it is not the policy to induce labour on social grounds alone. The reasons for these inductions are, therefore, irrelevant to the present study because such women would not have been considered to have normal prolonged pregnancies.

Our patients were well matched for parity, age, and smoking habits. The mean (SD) age for the