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We may return unduly long letters to the author for shortening so that we can offer readers as wide a selection as possible. We receive so many letters each week that we have to omit some of them. Letters must be signed personally by all their authors. We cannot acknowledge their receipt unless a stamped addressed envelope or an international reply coupon is enclosed.

Reproductive mortality

SIR,—The study of reproductive mortality is an important but difficult topic.^{1,2} The analysis by Dr Valerie Beral (15 September, p 632) is one of several that have been made. All efforts of this type involve a good many assumptions. For example, Dr Beral makes at least 11 assumptions in her calculation of reproductive mortality rates about such items as contraceptive risks, prevalence of use, and the relation between risks in ever-users and in current users. When different assumptions are used, different estimates may be obtained. For example, Tietze³ has derived contraceptive method mortality rates, and for oral contraceptive users has given them for smokers and non-smokers aged 25-29, 30-34, 35-39, and 40-44. On the assumption of an average mortality rate of 1.8 per 100 000 pill non-smokers and 6.2 per 100 000 pill smokers aged 25-34 and 5.3 per 100 000 pill non-smokers and an average rate of 35.6 per 100 000 pill smokers aged 35-44, and assuming 64% of the pill users were smokers,⁴ the reproductive mortality rates shown in the accompanying table are obtained. The con-

clusion of this analysis is that since 1960 reproductive mortality has declined among women aged 25-34 but remained stable among women aged 35-44.

A risk factor other than age and smoking is the duration of oral contraceptive use; for some pathological conditions the risk of death increases with the duration of oral contraceptive use.⁵ It is reasonable to assume that the group of women aged 35-44 years contained more long-term users (five or more years) than did those aged 25-34 years. Adjustments to the reproductive mortality rates for the differing proportions of long-term pill users would certainly result in a reduction in the rates for the 35-44 year old group.

Where so many assumptions are involved it is probably wise to move towards presenting a range of estimates rather than a single estimate. Estimates are country specific and may well be group specific. For example, in a country without access to legal abortion or one with a poorly developed midwifery service patterns of reproductive mortality will be greatly different. Moreover, estimates need to

be constantly reviewed and cross-checked in other ways. For example, Belsey *et al*⁶ and other WHO colleagues recently reviewed the vital statistics of 21 countries and found that cardiovascular disease among women continued to decline in nearly all countries (including England and Wales) during a time of expanding prevalence of oral contraceptive use. They concluded that oral contraceptive risks may be lower than some other investigators have previously suggested. A more detailed analysis of US data confirms the WHO's work in greater detail.⁷

We suggest that, although reproductive mortality is an innovative idea, estimates must be made continuously and critically. Data from a wide range of sources should be kept under review and the large number of assumptions necessary for any estimate emphasised.

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Reproductive mortality rate (per 100 000 women per year) for women aged 25-34 and 35-44 in England and Wales in 1950, 1960, 1970 and 1975

	Women aged 25-34				Women aged 35-44			
	1950	1960	1970	1975	1950	1960	1970	1975
Beral's analysis	8.7	5.2	2.8	2.4	6.2	2.9	3.7	5.0
Present analysis	8.7	5.2	2.9	2.5	6.2	2.9	2.5	2.8

¹ Potts, D M, and Swyer, G I M, *British Medical Bulletin*, 1970, **26**, 26.

² Tietze, C, *International Journal of Gynecology and Obstetrics*, 1979, **16**, 456.

³ Tietze, C, *Contemporary Obstetrics and Gynecology*, 1978, **12**(1), 32.

⁴ Vessey, M, *et al*, *Journal of Biosocial Science*, 1976, **8**, 373.

⁵ Royal College of General Practitioners Oral Contraceptive Study, *Lancet*, 1977, **2**, 727.

⁶ Belsey, M, Russell, Y, and Kinneer, K, *International Family Planning Perspectives* 5:2, 1979, **5**, 2.

⁷ Tietze, C, *International Family Planning Perspectives*, 1979, **5**, 12.