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Correspondents are urged to write briefly so that readers may be offered as wide a selection of letters as possible. So many are being received that the omission of some is inevitable. Letters should be signed personally by all their authors.

Coronary care unit or ordinary medical ward?

SIR,—The report by Dr J D Hill and his colleagues (9 July, p 81) is a potentially valuable contribution to improved coronary care and a stimulus to the kind of thinking with which we should regard all "obvious" solutions (here, the coronary care unit (CCU)). While not truly prospective and not randomised, as the authors duly note, their investigation forms a rational basis for an appropriately designed, prospective randomised trial. (In truth, there are nearly always ethical and scientific bases for randomising, but this study should strengthen the faint-hearted.) In many settings it is likely that many of the acts of mercy that we visit on our patients are not without peril. Thus it is conceivable that the similarity between CCU and ward mortality of acute myocardial infarction may not be due to comparable levels of care but rather to the loss of otherwise salvageable patients by some of the procedures in the procedure-orientated CCU. There is abundant evidence that invasively instrumented subjects (human or animal) differ significantly from non-invasively instrumented individuals—for example, the much greater tendency to faint during head-up tilting in catheterised persons than in those studied non-invasively. Exercise testing is another example: the presence of an intra-arterial catheter affects responses very much like a pre-exercise "warm-up." It is likely that CCU patients receive more than ward patients in the way of "routine" arterial and venous catheters and wires, including

Swan-Ganz catheterisation. The effects of these procedures in changing the individual and his responses to pharmacological interventions as well as to the course of his illness (for example, the ventricular fibrillation threshold) have not been established. The CCU procedures may well have their own benefit:loss ratio, quite apart from obvious (mechanical) complications. Even the CCU environment may be inimical to recovery for some patients.

Oestrogen treatment and endometrial carcinoma

SIR,—Your recent leading article (23 July, p 209) is misleading in several important aspects. We disagree with the innuendo that the efficacy of oestrogen therapy in the relief of menopausal symptoms is unproved, and previously in these columns¹ we have answered Mulley and Mitchell, who have questioned the rationale and efficacy of exogenous oestrogens in the treatment of menopausal flushing.^{2,3} Therefore menopausal oestrogen therapy is "fashionable" because it is effective and it is against this background that the risks of therapy must be assessed.

With careful selection of the available literature two seemingly impregnable arguments can be constructed; one incriminates oestrogens as a cause of endometrial cancer and the other concludes that on present evidence no cause-and-effect relationship is proved. Your leading article plainly states the former

While the otherwise excellent report by Dr Hill and his colleagues is most welcome, I have only one caveat: the sentence "There was also a natural tendency to admit older patients to a ward." Why was there such a tendency? And why is this regarded as "natural"? Undoubtedly the CCU was considered the superior locus. Should a randomised study yield the opposite conclusion, will it then be "natural" to admit older patients to the CCU?

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argument. However, the criticisms of the retrospective studies which first suggested an association between oestrogens and endometrial cancer are not only incompletely presented but are dismissed rather simplistically as "invalid." It is true that cases and controls should be matched for "factors which may be related to the disease," but in all published studies⁴⁻⁷ this has not been accomplished. The types of bias inherent in retrospective case-control investigation have been elegantly detailed⁸ and the one study which reduced bias by allowing cases and controls to emerge from a group of women admitted for the same diagnostic procedure (curettage) showed no association between oestrogens and endometrial carcinoma.⁹ These workers concluded that oestrogens, through an association with uterine bleeding, resulted in an increased diagnostic detection of carcinoma. Oestrogen-