Correspondence

Letters to the Editor should not exceed 500 words.

Family Planning in London Teaching Hospitals

SIR,—The Family Planning Association has for some years been running courses to instruct doctors, midwives, and nurses in family-planning advice and in teaching of family planning. It was important to the Association to know how much other teaching was going on, especially in teaching hospitals, and they therefore wrote to a senior consultant in each of 11 London teaching hospitals to inquire what teaching was being provided as to: (a) advice on contraception to maternity and gynaecological patients, either routinely or on request; (b) instruction in contraceptive techniques to medical students, midwives, and nurses, routinely or as requested; (c) referral of patients to family-planning clinics outside the hospital either routinely or on request. The Association did not write to one London teaching hospital where (a) and (b) were known to be standard practice. This hospital has a famous professorial unit, to which has been attached for years a sympathetic senior woman doctor who specializes in teaching contraception and giving advice to selected patients.

The Family Planning Association showed me the replies from the various teaching hospitals, and asked me to make a general comment on them. It is as follows:

It was clear from the answers received that the consultants did not consider it a part of their duties to instruct midwives or nurses at all in contraceptive techniques in any of the London teaching hospitals. And it would appear that no course is given by doctors at all, with one exception, in any London teaching hospital to nurses or midwives.

It would equally appear that, apart from occasional lectures, most of the medical students in London, again with the exception of one hospital, receive only one formal lecture on contraceptive technique, and do not receive proper lecture demonstrations. The teaching can hardly be sufficient to enable any doctor to go into general practice equipped to instruct women in the different contraceptive techniques now available to them, nor adequately to advise their patients how to avail themselves of contraception, except by referring them to a Family Planning Association Clinic. Clearly, each consultant was aware that at the present time the best advice that could be given to a student who wanted to learn was to attend the Family Planning Association for formal instruction.

It is worth while speculating on the reasons for such scanty instruction in contraception. A senior consultant gynaecologist spends his week seeing gynaecological patients and operating on them, seeing some antenatal patients and perhaps delivering a few women, and in giving formal lectures on gynaecological disease and on the normal and abnormal in obstetrics.

Few of the London teaching hospitals routinely accept in large numbers cases of

criminal abortions, because these are not good teaching material. The aftermath, therefore, of failure in contraception may not have the same impact on consultants in teaching hospitals as on those working in non-teaching hospitals, although in fairness many of the consultants work in both types of hospital. The full social consequences of failure to instruct doctors and midwives in contraception is seldom as obvious in hospitals as it is in general practice, where the doctors see the patients' home conditions at such close quarters. Perhaps, too, the teaching of rather dull repetitive techniques does not have the same appeal as the teaching of the more dramatic abnormal.

At a time when some organizations are more strongly than ever advocating that contraception is "the teaching of the devil," and others are stating that without it we will have nothing to eat, the situation at the London teaching hospitals may be of interest to your readers.—I am, etc.,

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ELLIOT E. PHILIPP.

Endocarditis as a Cause of Cerebrovascular Lesions

SIR,—One has always tended to believe that embolic or mycotic aneurysms arising in the middle cerebral arteries, and less often in the anterior cerebral artery, were uncommon manifestations of subacute bacterial endocarditis unless other florid stigmata were present simultaneously.

A patient presenting with a sudden hemiplegia can be so easily diagnosed as having a non-specific cerebrovascular accident, but during the last few months I have seen three such elderly patients admitted as emergency cerebrovascular accidents. In each case there was initial failure to diagnose subacute bacterial endocarditis until a deterioration in the neurological state occasioned a reappraisal. Unfortunately, however, valuable time was thus lost in instituting intensive chemotherapy. Subsequent necropsies revealed the classical appearances of endocarditis; the bacteria invading a valve damaged by rheumatic endocarditis, in the form of mitral incompetence in two cases, and one damaged by calcific aortic stenosis in the remaining case. No past history of rheumatic fever was elicited from the patient or the relatives, and there were no symptoms of illness before the sudden hemiplegia.

On further examination the following signs should have shown me the correct diagnosis. A low-grade intermittent pyrexia was noticeable in two cases, although the third case was apyrexial. Cardiac murmurs became audible after positioning each patient; a pansystolic murmur was present at the apex in two cases and a midsystolic at the aortic

base in the remaining case (initially these bruits had been considered to be ejection in type). Early clubbing of the fingers was apparent in two cases only. Two splinter haemorrhages beneath the nails in one case and four in another case were only just discernible. One patient complained of sudden blindness in the left eye of six weeks' duration; retinoscopy indeed revealed an embolic occlusion of the central retinal artery, which should have led to an earlier diagnosis. There was also slight splenomegaly in one case. A mild normocytic and orthochromic anaemia was noted in two patients. The only abnormality found in the urine on microscopic examination was the presence of a few red blood cells in one case only.

As soon as the possibility of subacute bacterial endocarditis was seriously considered blood-cultures for *Streptococcus viridans* were immediately performed, and were repeatedly positive in two of the three cases.

I would like to make the point that in my experience subacute bacterial endocarditis masquerading as a simple cerebrovascular lesion is much commoner than is currently thought, especially in the elderly patient, and to make a plea that it should always be considered as the possible underlying pathology in these lesions.—I am, etc.,

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Cerebrovascular Accidents and Oral Contraception

SIR,—Since 1961 there have been reports of the occurrence of thrombophlebitis and pulmonary embolism in women taking oral contraceptives.^{1,2} Egeberg and Owren³ studied blood coagulability in women taking Enavid (norethynodrel + ethinyloestradiol 3-methyl ether) and reported an increase in factor VIII and possibly an increase in factor VII. I am therefore prompted to report two cases of cerebrovascular incidents in young women taking oral contraceptives.

Case 1.—Mrs. A. B., aged 23, was admitted to the National Hospital, Queen Square, under the care of Dr. Macdonald Critchley on 6 June 1963. She was an airline stewardess who had been flying over international routes for three years, and had flown that day from the United States in a pressurized aircraft. During the flight she had an episode of feeling unreal and had a sensation of falling which lasted 15 minutes. After a short interval a similar episode occurred and lasted 20 minutes. On landing 20 minutes later she was confused and had difficulty with her speech. On admission to hospital two hours later she was disorientated and had difficulty in naming objects. She was right-handed. She showed weakness of the right side of the face and weakness of the right hand. The tendon reflexes were exaggerated in the right arm. She had two birth marks of the strawberry naevus type, one situated in the natal cleft and the other on the lateral border of the right foot. There was no neck stiffness, no swelling of the legs or tenderness of the calves. Examination of the heart revealed no abnormality.

Her blood-pressure was 120/80. Investigation showed a haemoglobin of 12.3 g./100 ml. and a total white cell count of 9,700/c.mm. The E.S.R. was 18 mm. in the first hour. Cerebrospinal fluid examination showed two lymphocytes per c.mm. and a protein of 40 mg. per 100 ml. X-ray examination of the skull and chest was normal. A left carotid angiogram was normal. A lumbar air encephalogram was also normal. An electroencephalogram showed delta activity at 2½ cycles per second in the left fronto-temporal area. She improved rapidly over the course of the next four weeks, although she still showed some nominal dysphasia when last seen on 5 July 1963. A written report about her on 7 April 1964 revealed that she had then made a complete recovery.

Oral contraceptive regime.—The patient started taking Enavid on 19 April 1963. She took two tablets daily from 19–23 April. She then had heavy menstrual bleeding lasting from 24 to 28 April. From 29 April to 17 May she took one tablet of Enavid daily. Because she developed very slight vaginal bleeding from 7 May she was advised to discontinue the tablets on 17 May. On 5 June, with her menstrual period two weeks overdue, she took two Enavid tablets. The next day she became ill on the flight to London. She stopped taking the tablets and her periods returned to normal in July.

Case 2.—Mrs. X. Y., aged 26, was seen at the West Middlesex Hospital on 27 December 1963 by Mr. Douglas Langley. She complained that six weeks previously she noticed that "something was wrong with her vision" on waking. Examination revealed a congruous left upper quadrantic field defect. She was seen in the neurological clinic on 17 January 1964. There were no abnormal physical signs apart from the field defect; in particular the pulse was regular, there was no cardiac murmur, no bruit to be heard over the cranium, and no tenderness of the calves. The field defect was unchanged when she was seen again on 10 April 1964. In her past history she had epileptic seizures at the age of 17 years, was taking phenobarbitone, and had no further seizures since the age of 19 years.

Oral contraceptive regime.—The patient had had two normal pregnancies in 1959 and 1961. She started taking Ortho-Novin (norethisterone 2 mg., mestranol 0.1 mg.) in June 1963. She took one tablet daily for 20 days of each menstrual cycle. She stopped taking them after the visual disturbance in December 1963.

The most likely explanation of the clinical picture in both cases is that they had a small cerebrovascular episode. There was no obvious source for an embolus. It is, of course, true that even young people can, rarely, have cerebrovascular lesions from no apparent cause. However, both cases were young women taking oral contraceptives. Lorentz⁴ reported the case of a 41-year-old woman who developed a left parietal lesion whilst taking 20 mg. of Enavid daily for three months, for painful symptoms associated with menstruation. A presumptive diagnosis of cortical venous thrombosis was made and she had residual neurological signs. In her case the dose of Enavid was of course many times higher than that recommended for contraceptive purposes.

It is noted that two private reports (one of a conference on thromboembolic phenomena in women, held in Chicago in September 1962; and one on Enavid submitted to the Food and Drug Administration in September 1963) failed to demonstrate any significant increase in the risk of thromboembolic death from the use of Enavid.

While final judgment about the relationship of progestagens to thromboembolic incidents must be reserved, it is apparent that these cases should be reported and that

medical practitioners should be aware of the possible hazards of the use of these drugs.

I am indebted to Dr. Macdonald Critchley for permission to report Case 1 and Mr. Douglas Langley, F.R.C.S., for Case 2.

—I am, etc.,

London W.C.1.

K. J. ZILKHA.

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Oral Contraceptives and Liver Damage

SIR,—The report on hepatic impairment during the intake of contraceptive pills by Dr. A. Eisalo and his colleagues (15 August, p. 426) is interesting and we would like to make some comments. Our observations lend support to the view that the oestrogens in the pills may be the most important constituents causing liver damage.

Many similarities can be found when steroid-induced jaundice¹ and idiopathic or recurrent jaundice of pregnancy^{2–4} are compared. Both the clinical picture and the laboratory results suggest impairment of the excretory function of the liver and also some damage to the liver cells which causes elevation of serum transaminases. Of all hormonal steroids the oestrogens show the most augmented excretion during pregnancy. Both the oestrogens and bilirubin are excreted in conjugated form in the bile. However, in recurrent jaundice of pregnancy the excretion of bilirubin into the bile is impaired as well as that of oestrogens.⁵ In the Dubin-Johnson syndrome bilirubin conjugation is normal, but excretion into the bile is impaired, and the excretion of oestrogens into the bile of these patients also seems to be disturbed.⁶ In the Bongiovanni-Eisenmenger syndrome only synthetic oestrogens give rise to jaundice.⁷ It should also be mentioned that some of the anabolic steroids which have been reported to cause jaundice are converted to a small extent into oestrogens. All these observations suggest a close connexion between the metabolism of bilirubin and of the oestrogens.

We have observed three cases of jaundice due to contraceptive pills. Ikonen⁸ has described the case history of a woman who had jaundice during two successive pregnancies and after this a third time following administration of Anovlar (norethisterone acetate + ethinyloestradiol). The clinical symptoms as well as the laboratory findings were very similar. Adlercreutz⁹ reported two cases. The first woman had severe pruritus (which is said to be a prodrome of jaundice) during the end of her second pregnancy (first pregnancy interrupted). Half a year later she developed jaundice following intake of Conovid (norethynodrel + 3-methoxy-ethinyloestradiol). Two years later she received Lyndiol (ethinyloestrenol + 3-methoxy-ethyl-oestradiol), but had to stop the intake after 20 days owing to migraine, vomiting, and pain under the right costal margin (no gallstones present; ? biliary dyskinesia). Then she received only Orgametril (ethinyloestrenol) for 60 days without any side-effects. After this she started to take Lyndiol again and after 20 days was very ill with vomiting, pruritus, migraine, and pain under the right

costal margin. Ten days later she became jaundiced (bilirubin 12.3 mg./100 ml.). It should be pointed out that the main difference between the drugs causing liver disease and the one that was well-tolerated was the content of a synthetic oestrogen in the drugs causing jaundice and high serum transaminase. The second case reported by Adlercreutz⁹ was of a patient only 19 years old who had had no pregnancies. She developed the same type of jaundice as the other two cases described. It is interesting to note that she had a history of migraine and biliary attacks (no gallstones).

There is no definite evidence to suggest that the same mechanism is responsible for the jaundice during pregnancy and that caused by the contraceptive pills. However, it seems possible that all three patients had some sub-clinical disturbance of liver function which was aggravated by the contraceptive pills or the pregnancy.—We are, etc.,

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Buccal Oxytocin

SIR,—The following case report illustrates the danger of buccal oxytocin and is presented in support of Dr. F. A. Best (10 October, p. 942) and others who have recently condemned its use.

A.B., aged 38, para. 7, was admitted to the Maternity Department, Galway Regional Hospital, on 11 October with secondary post-partum haemorrhage. On 28 September 1964 she had had a low forceps delivery at term, outside our service. Twenty-four hours after spontaneous rupture of the membranes labour was not established and three buccal tablets Pitocin (oxytocin) were given over a period of three hours. There was apparently no response until after the third tablet; thereafter there were very strong uterine contractions and delivery took place within one half-hour. There was slight vaginal bleeding on the third post-partum day with a recurrence of bleeding three days later. Severe bleeding with collapse occurred on 11 October, and the patient was attended by the obstetrical flying squad and taken to hospital after resuscitation. Examination under anaesthesia revealed a transverse tear about 2 in. (5 cm.) long in the lower segment above the bladder reflection, and this was confirmed at laparotomy; there was some organizing blood clot and granulation tissue adherent to the edges of the uterine rupture. Because of pyrexia and intestinal distension treatment was by total hysterectomy with conservation of both tubes and ovaries; convalescence, so far, is satisfactory.

—I am, etc.,

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