Oral Contraceptives, Thrombosis, and Cyclical Factors Affecting Veins

SIR,—Dr. G. I. M. Swyer's letter (5 February, p. 355) calls for some comment. My observations (1 January, p. 51) were directed exclusively to the question of venous thrombosis, and my tentative approach is clear from the last paragraph of my letter.

Dr. Swyer points out that the Registrar General's statistics do not suggest any appreciable alteration in mortality from thromboembolic disease since the introduction of oral contraceptives. But most thrombophlebitic disease is not reflected in such statistics. My records of 2,400 vein cases and complications cover congenital conditions, varicose diseases, deep thrombosis beyond the acute phase, thrombosis in the upper limb, etc. Whatever the complications and clinical anxieties of those cases, there was only one of immediate interest to the Registrar General.

Whilst sheltering from Dr. Swyer's statistical barrage I was provided with the pharmaceutical literature dealing with 13 unselected oral contraceptives. In 9 of the 13 there was a caution that the preparation should not be used by women with a history of thrombophlebitis. Is this advice given on purely theoretical grounds?

Thrombophlebitis is common in women of childbearing age, and invariably develops in incompetent or varicose veins. In a series of 769 personal cases of varicose veins analysed in 1937 there was an incidence of 18.2% of phlebitis amongst 499 married women, and of 8.5% of phlebitis amongst 270 single ones. Phlebitis is related to age, parity, and the efficiency of any antecedent treatment of varicosities. One attack predisposes to others, but the condition is rarely fatal.

In a smaller group thrombophlebitis follows an antecedent deep thrombosis, often puerperal, post-operative, traumatic, or infectious in origin, or secondary to thrombophlebitis in varicose veins. My experience does not suggest that there is a type of non-fatal manifest deep thrombosis in the absence of a definite background factor. That is certainly not to say that such cases do not occur or that a fatal pulmonary embolus cannot occur in a healthy young woman. Some of the "shelter legs" of the last war probably came into this category. On the other hand it is certain that thrombophlebitis in women of childbearing age is not typically a process developing in normal veins.

Another suggestive piece of evidence has just reached me from a surgeon experienced in vein problems. He reported the case of a woman who had a small vein in one leg which could hardly be called varicose. On starting the pill the vein enlarged and the patient almost insisted on treatment. Within a month of giving up the pill the vein became much less visible.

Tremendous pressures now surround the subject of contraception, and the finer points of clinical observation may be lost in the outlook of "crash programmes of population control." I have seen many women of childbearing age to whom it has been necessary to give advice about vein problems, including thrombophlebitis, in relation to pregnancy. I shall continue to keep an open mind about a possible relationship between oral contraceptives and thrombophlebitis,

but I cannot believe that the warnings given by the manufacturers should be entirely ignored.—I am, etc.,

London W.1.

REGINALD T. PAYNE.

**Clinicopathological Conference
Electrocardiogram**

SIR,—The electrocardiogram published in the Clinicopathological Conference (5 February, p. 345) must surely be an error. It is described in the text by Professor Goodwin as showing right axis deviation, right ventricular hypertrophy with large "p" waves in lead II. This was of course consistent with the diagnosis of pulmonary fibrosis.

However, the published electrocardiogram shows slurred QRS complexes in I, AVL, and even AVR, with deep S waves in II, III, and V 1-3, and even V4R, with upright T waves in the right chest leads.

This surely is the picture of left ventricular hypertrophy with left axis deviation.—I am, etc.,

F. H. POPE.

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SIR,—In the Clinicopathological Conference about the patient with idiopathic lung cavitation (5 February, p. 345) the electrocardiogram was considered to show right axis deviation of the mean frontal QRS vector. In the electrocardiogram shown, lead I indicates that the mean frontal axis is directed to the left, since it is dominantly positive. The markedly negative lead II indicates that the axis is abnormal and, since lead I is positive, it means that there is left axis deviation exceeding minus thirty degrees. Lead VR is dominantly positive and therefore the left axis deviation also exceeds minus sixty degrees. Since the left ventricle was normal at post-mortem examination it is probable that this abnormal axis results from rotational changes in the electrical position of the heart due to the lung disease.

Professor Goodwin invokes a similar explanation for deep S waves in the left precordial leads. As he points out, these rotational changes are common in those with obstructive airways disease. Left axis deviation, as in this case, is not rare.—I am, etc.,

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* * We showed these two letters to Professor J. G. Goodwin, whose reply is printed below.—ED., *B.M.J.*

SIR,—Your correspondents are absolutely correct in questioning my interpretation of the electrocardiogram published in the Clinicopathological Conference of 5 February 1966. The description in the discussion applied to another electrocardiogram which was omitted in error. I must apologize to your readers for this mistake, and would like to thank your correspondents for kindly pointing out the discrepancies and for their excellent interpretations of the published electrocardiogram.—I am, etc.,

J. F. GOODWIN.

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Working Capacity of Women Doctors

SIR,—In their letter to you (5 March, p. 610) Professor J. Knowelden and Dr. J. E. Lunn suggest that the results of the inquiries into the work of women doctors undertaken by the M.W.F. and M.P.U. in 1962-4, and reported in your journal (12 February, p. 409), may have been biased by the non-response of approximately a quarter of the population surveyed.

We have been invited to prepare a report of the M.P.U. inquiry, and since this is shortly to be published we do not wish to comment on a single aspect of the findings. However, a study of some of the characteristics of the non-respondents to that inquiry showed that relatively more of them than of the respondents were women of 55 and over who had qualified before 1939. Conversely, there were proportionately fewer recently qualified women among the non-respondents; but the M.P.U. question form was not sent to women who registered provisionally during 1962 and 1963. The inquiry was not representative, therefore, of this group of medical women.

In our report we try to estimate the effect on employment of changing patterns of marriage and maternity, and we agree with Professor Knowelden and Dr. Lunn that there is reason to feel concern about the extent to which the skills and knowledge of women doctors are being used in the health services.—We are, etc.,

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Visiting Children

SIR,—It is surely unnecessary to regard Dr. John Bowlby (29 January, p. 297) and Dr. John Howells (12 March, p. 676) as protagonists of opposing causes. Both are concerned with the provision of optimal conditions for emotional growth in childhood. Dr. Bowlby drew attention to work, his own and that of many other distinguished workers in the field, which appeared to indicate that "the growing child needs a warm, continuing relationship with a mother or mother surrogate in which both find satisfaction." He warned that the separation of mother and child might disrupt this needed relationship, and in a minority of cases—whether by reason of exceptional features in the disrupted relationship or in the constitution of the child—severe personality disturbances may result. This hypothesis was readily accepted as confirmation of clinical experience by many workers in this field.

Dr. Howells makes the equally acceptable assertion that "separation can, in certain circumstances [the italics are mine], lead to boundless benefit to the child." Again clinical experience would support this, but clearly Dr. Howells does not suggest that every maladjusted child should be separated from his mother.

Each child is a unique individual whose needs require individual assessment. Whether our concern is to determine how frequently