Correspondence

Letters to the Editor should not exceed 500 words.

Intrauterine Contraceptive Devices

SIR,—In your leading article on this subject (31 July, p. 249) you rightly state that: "Few medical men in Britain are yet familiar with these new intrauterine contraceptives, but trials are beginning. . . ." The obvious and correct implication of these words is that some doctors already are experienced in their use. As you are well aware, the *British Medical Journal* enjoys a wide circulation in countries other than Britain, in many of which the population problem is one of the most serious which Governments have to face. In India, for example, the population is increasing by nearly one million a month, and in the formidable task of bringing this under control every possible measure must be considered and appraised. With this background your leading article could possibly be misleading.

It is fair to say that: "The claims made for the intrauterine device deserve careful examination." The International Planned Parenthood Federation is sponsoring trials in many countries where the need is urgent. It is perhaps not so fair to refer in the concluding paragraph to the "popular appeal of the intrauterine contraceptive device," to "the irksome daily routine of the contraceptive pill," and the usefulness of the device, "especially perhaps in under-developed, over-populated areas where illiteracy, cultural taboos, and shortage of medical staff and facilities make other methods of contraception impracticable."

At a recent Seminar on Population Control held in Bombay by the Federation of Obstetrics and Gynaecology of India, Dr. McBride, of Australia, speaking from a considerable experience of intrauterine devices, described them as the slow bowlers of the population control team, and oral contraceptives as the fast bowlers. Both are necessary in any well-balanced team and the contribution each can make is not increased by underrating the value of the other. It was not surprising that an Australian should remind his audience that the fast bowler usually opens the attack. Dr. McBride considered that oral contraception was a more rapid and effective weapon for reducing the birth rate than the intrauterine contraceptive device, but both had a role to play.

Your article referred to the popular appeal of the I.U.C.D. but it is questionable whether this exists when oral contraception is also available and the public is reliably informed on the relative advantages and disadvantages of the two methods. For example, in family planning clinics in Great Britain interest in oral contraception has been so great that the number of patients choosing it rose from 3,536 in 1962 to 13,670 in 1963 and to 44,000 in 1964. On the other hand, in Taiwan, where a vigorous effort is being made to insert 600,000 I.U.C.D.s in five years, the

Maternal and Child Health Association sponsored a separate study to measure the response to a suggested mail order service for oral contraceptives. Following a small newspaper advertisement on 22 April there was such an enthusiastic response that the supply of tablets was inadequate to satisfy the demand. By 19 May 555 patients had registered for supplies. The accumulated evidence from many countries suggests that the "irksome daily routine" is more than compensated for by the security oral contraception provides.

Finally, your reference to the undoubted value of the I.U.C.D. in under-developed countries where "shortage of medical staff and facilities make other methods of contraception impracticable" fails to give a realistic appreciation of the logistics of a campaign to insert devices in just such a community. To return once again to the experience from Taiwan, by April 1965 the number of devices inserted had risen to 10,500 a month, with 405 doctors and 303 field workers engaged in the project, an average of 26 insertions a month by each doctor. Here is a strong case in support of the view that a shortage of medical staff and facilities provide just the circumstances in which the limited available staff could make their greatest contribution by imaginative local adoption of oral contraceptive techniques, if they were permitted to do so and were given the necessary supplies.

For practical purposes there are now two methods of contraception, the oral tablet and the I.U.C.D., the one giving virtually 100% security and the other 95%, provided both are intelligently used. Both methods have disadvantages and are certain to be improved, but any realistic assessment of the magnitude of the population problem facing the world must take both into account.—I am, etc.,

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J. STALLWORTHY.

Oral Contraceptives and Blood Coagulation

SIR,—May I be allowed to comment on the paper by Jean M. Thomson and Dr. L. Poller (31 July, p. 270), who reinvestigated this important subject? None of the data presented substantiates a conclusion condemning oral contraceptives as being definitely responsible for thrombosis.

The main finding in the group receiving these drugs is a slight increase in factor-VII concentration, which as the authors demonstrate is not quite the same anomaly as that found in patients with thrombosis. Furthermore, there is no mention of the incidence of thrombosis in the 40 patients studied, all of whom showed this change in the blood-clotting mechanism. Whether an increase

in the level of a blood-clotting factor accelerates or hinders blood coagulation is a moot question.¹⁻³ However, there is no work showing any increase in factor-VII concentration as precipitating thrombosis, the reported changes being studied after thrombosis has occurred. For all we know, this increase in factor VII, or any other factor¹ for that matter, may be part of a compensatory mechanism preventing further thrombosis.

To arrive at definite conclusions regarding the relation between thrombosis and oral contraceptives, an extensive long-term survey is required, comparing with statistical analysis the incidence of thrombosis in women receiving the drug with that in a comparable group of the general population. This, I believe, is being investigated by the Dunlop Committee on Safety of Drugs.—I am, etc.,

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- ² Quick, A. J., *ibid.*, 1963, 1, 744.
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Oral Contraceptives and Liver Damage

SIR,—There is a considerable controversy as to whether the oral anovulatory steroids cause liver damage. Eisalo and his colleagues¹ reported an increase in the S.G.O.T. and S.G.P.T. levels in the serum of post-menopausal women receiving one to two tablets of Lyndiol daily. The transaminase values were usually elevated within 20 days of treatment. Similar results have been obtained in other studies.²⁻⁴ Other investigators⁵⁻¹⁰ do not believe that these steroids cause liver damage. In women of child-bearing age Eisalo *et al.*¹¹ in a later communication report an increase in serum transaminase levels in 18% of women taking Lyndiol. Brain, Parkes, and Bishop¹² have stated that more information is needed on the possible hepatotoxic effect of these steroids. There do not appear to be any reported studies where S.G.O.T. levels have been estimated before and after administration of steroids in the same experimental animals.

In the experiments performed in this laboratory Noracyclin was administered to a group of five female rabbits weighing approximately 1 to 2 kg. at a dose of 0.1 mg./kg. (17 α -ethinyl-oestradiol 0.1 mg./kg. and 3-methoxy-15 α -ethinyl oestradiol 0.003 mg./kg.) five days a week by means of a soft rubber catheter. The S.G.O.T. level of the serum of each rabbit was estimated after the method of Cabaud *et al.*¹³ 15 days and 8 days before administration of the drug. The S.G.O.T. level was also estimated at 3, 8, 15, 22, 29, 36, and 43 days after commencement of administration of the drug. The drug was not fed longer than 40 days, as Eisalo and his colleagues¹ reported an elevation of S.G.O.T. levels 20 days after the drug was administered.

In another similar experiment Orthonovin was administered to female rabbits at a daily dose of 0.04 mg./kg. (norethisterone 0.04 mg./kg. and mestranol 0.002 mg./kg.) and S.G.O.T. levels

TABLE I.—S.G.O.T. Value in Units in Rabbits Before and After Noracyclin Administration

Rabbit No.	Days								
	-15	-8	3	8	15	22	29	36	43
1	4	5.5	—	1.5	1	2	1.5	2	1
2	4.5	3	3	1.5	<0.5	3.5	4.5	6.2*	—
3	4	1	5.75	2	<0.5	1.5	1.5	1	2
4	0.5	4	3.75	2.5	0.5	1	2	1.5	2.5
5	0.5	1	2.5	1	1.5	2	1.5	2.5	1

* Rabbit had fracture right hind limb on 26 April 1965 and was sacrificed on 14 May 1967.

TABLE II.—S.G.O.T. Value in Units in Rabbits Before and After Orthonovin Administration

Rabbit No.	Days								
	-15	-8	3	8	15	22	29	30	43
1	1.5	4	3.5	3.5	2	3	2.5	4	3.5
2	1	2	2.5	2	1.5	3	2	1.5	2
3	4	2.5	3	2.5	3	3.5	2	2.5	2
4	5	7.5	4	3	4.5	4	3.5	2	5
5	4	0.5	2	2.5	3	1	1.5	2	2

estimated at similar intervals before and after feeding of the drug.

The results of the first series of experiments can be seen in Table I and the second series of experiments in Table II. It can be seen that the normal serum S.G.O.T. values varied from 0.5 unit to 7.5 units. In no instance did the S.G.O.T. value suddenly rise after administering the steroid to any rabbit. In only one animal the S.G.O.T. level rose to 6.2 units from 0.5 unit after it suffered an injury to the right hind-leg which was possibly responsible for this rise. This rabbit had to be sacrificed. The results obtained with these two anovulatory steroids indicate that in rabbits they have shown to be devoid of any hepatotoxic effect when hepatic damage was evaluated by estimating the S.G.O.T. level in serum. This is the method which Eisalo *et al.*¹ have mentioned as being the only one which would detect these changes. These authors state that this type of hepatic injury cannot be detected by tests like total bilirubin or alkaline phosphatase.

Further studies are proceeding with other anovulatory steroids, and the possible hepatotoxic effect or absence of such effects of these substances on animals with hypoproteinaemia will be investigated. A large proportion of women to whom these steroids will be administered for purposes of fertility control in India may be hypoproteinaemic.

Role of the Child Psychiatrist

SIR,—Your series of articles on Child Care in General Practice, in which specialists in various subjects have addressed themselves to the family doctor, have been most instructive. As these articles have been clearly practical in their aim, I was surprised that for many months scarcely any reference was made to emotional disturbance—a subject about which the general practitioner is frequently consulted. However, this omission has now been made good by three articles on "Emotional and Behavioural Disorders."¹ But I am disappointed to see that the author is not a specialist in this field—i.e., a child psychiatrist—but a paediatrician. Dr. Apley's researches into the psychosomatic disorders of children are well known; so also is his excellent book on the subject, *The Child and his Symptoms* (co-author Dr. Ronald Mac Keith). But the choice of a paediatrician to write these articles is none the less to be regretted because it reinforces a commonly held idea that, in the case of children (and

We would like to thank Mr. S. K. Borkar, Drugs Controller of India, and Mr. P. S. Ramachandran, Assistant Drugs Controller, for their help in carrying out these studies.

—We are, etc.,

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this is not so with adults), emotional disorders can be as suitably dealt with by the physician as by the psychiatrist. Indeed, it is often felt that the paediatrician is preferable because he will not make too much of a case—as psychiatrists are popularly believed to do; whereas the possibility that he might make too little of it is gratefully overlooked by anxious parents who are above all seeking reassurance.

I am disappointed to find that Dr. Apley does nothing to dispel this idea. In referring to tics (in the first of his three articles) he says: "The few children whose tic is grotesque and becoming worse, or in whom there are obvious signs of emotional disturbance, need prompt treatment by a paediatrician or a child psychiatrist." But which? No guidance is given on this important issue. Yet the implication here (as elsewhere in these articles) is that the paediatrician is a specialist in these matters of equal competence to the psychiatrist.

Most paediatricians reach consultant status with no more than undergraduate training in psychology and psychiatry. In this respect they are in the same boat as general practitioners. Even so, many of them acquire, through experience and additional study, a broad understanding of emotional disorders in children and practical skill in handling them—at least in so far as this can be done by parental counselling. But in two respects they remain at a serious disadvantage in comparison with their psychiatric colleagues:

(1) Their lack of basic training in psychiatry leaves them unfitted to deal with difficult cases; and it is not easy to foretell which cases are going to be difficult.

(2) They do not have the facilities for investigation and treatment that are available to the child psychiatrist who works with a team of highly trained colleagues (educational psychologists, clinical psychologists, psychotherapists, and psychiatric social workers), whose services he can call upon as required.

I submit that the family doctor should be recommended to refer cases of emotional disorder directly to the child psychiatrist when specialist advice is needed. Far too often valuable time is lost and parents are confused by a child being referred to a paediatrician who, even if he has the experience, has no facilities for dealing adequately with cases that require more than parental counselling. —I am, etc.,

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REFERENCE

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Safety in Car Design

SIR,—The report of the papers given by representatives of the motoring industry at the Annual Meeting of the B.M.A. (31 July, pp. 288–289) would be very much more interesting if there was any indication that the manufacturers took the slightest notice of such experimental work.

Last year I purchased a car and discovered to my astonishment that the mirror provided was *convex*. One of the important functions of such a mirror is to provide information on the distance and speed of overtaking cars; although it is possible to do this with a *convex* mirror, it savours more of a conjuring trick than a simple procedure for ensuring safety. Furthermore, the manufacturers had recommended safety belts for the car which, when they were fitted, resulted either in the driver being pinned back in his seat and being scarcely able to drive or, when they were loose, rode upwards so that the "lap" belt would be sure to penetrate the intestines during a crash.

Our profession has much experience, professional as well as personal, of the remarkable lack of interest in safety by the car industry. When motor manufacturers cease to fit their cars with dangerous handles (designs based on the style of Boadicea's chariot), give up using absurd mirrors (of a design unchanged since the days when cars were preceded by a man on foot with a red flag), and provide adequate safety belts (which diminish rather than increase the dangers of an accident) we shall be prepared to believe that they are really interested in the problems of safety.—I am, etc.,

MAX HAMILTON.