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Postmenopausal oestrogen replacement protects against death from stroke

Stroke is one of the main causes of death and disability, but treatment is limited so control must be through prevention. Several recent studies have suggested that postmenopausal oestrogen replacement therapy (ORT) protects against death from cardiovascular disease, perhaps through a favourable influence on blood lipids. As some of the most important risk factors for heart disease are the same for stroke it makes good sense to see how ORT might affect the outcome of stroke. Paganini-Hill *et al* (p 519) have now done this by examining stroke mortality in a large and homogeneous retirement community in California. Nearly 9000 women returned a mailed health questionnaire which included details of ORT and medical history. Mortality data were collected from health department death certification. After six and a half years of follow up there had been 1019 deaths in their cohort, of whom 44% had not received ORT. The relative risk of death due to stroke in women who took ORT was 0·53 in comparison with those who did not, and this significantly reduced risk was maintained even after adjustment for possible confounding factors such as hypertension, smoking, alcohol, and exercise. The results therefore suggest that postmenopausal ORT protects against death from stroke.

Survival after myocardial infarction in New Zealand

Mortality from coronary heart disease is declining in many Western countries, but it is unclear whether this is due to there being fewer coronary events or to the events being less severe or whether better treatment is resulting in longer survival. If the cause of this decline in mortality were known then action might be able to be taken to accelerate the decline; and the increasing mortality in some other countries might be able to be halted.

At p 517 Stewart *et al* assess changes in mortality after myocardial infarction in New Zealand between 1966 and 1981. They conclude that infarcts seem to have become more severe but that survival after infarction has improved—and that this has made some contribution to the decline in mortality.

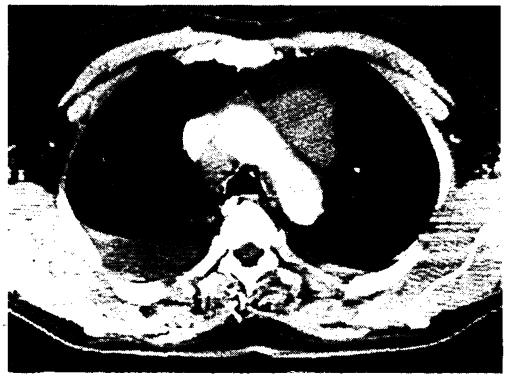
Mastectomy or tamoxifen for elderly patients with operable breast cancer

Some recent reports have suggested that tamoxifen is the treatment of choice for breast cancer in the elderly, even if the patient presents with an operable tumour. The temptation to treat elderly patients with operable breast cancer simply by tamoxifen without referral to a surgeon may be understandable, but does it deny patients the best available treatment?

At p 511 Robertson *et al* report a prospective study limited to elderly patients with operable breast cancer (lump <5 cm diameter) which compared the standard treatment—surgery—with the new treatment—tamoxifen—both in terms of survival and local control. Though survival was similar in the two groups, the control of local disease was better in the patients treated by mastectomy; that is to say that most patients treated with tamoxifen subsequently required mastectomy for local recurrence. These findings have important implications for the optimum treatment of patients with breast cancer.

Why record maternal height and shoe size in obstetric records?

For many years maternal stature has been considered to be a useful surrogate measure of pelvic adequacy and, along with shoe size, has been routinely recorded in obstetric case notes. Small women tend to have impaired obstetric performance with a higher chance of caesarean section, but evidence for an association between outcome and maternal height and between outcome and shoe size in the few studies that have been done has not been conclusive. Mahmood and colleagues re-examined these relations in 563 white Scottish primigravidas (p 515) and found an increased caesarean section rate in women of short stature, but no association between mode of delivery and shoe size. Nevertheless, 80% of mothers less than 160 cm tall delivered vaginally. The high caesarean section rate among smaller women may be as much due to the obstetrician's perception of the association between small stature and contracted pelvis as to actual cephalopelvic disproportion occurring in labour. When there are no other complications the authors recommend a trial of labour in all primigravidas with cephalic presentation irrespective of their height or shoe size.



Computed tomogram showing soft tissue mass in anterior mediastinum beside the aorta. The mass is a pericardial and mediastinal haemorrhage in a 48 year old man who proved to have acute pericarditis but at presentation was thought to have had a myocardial infarction, being treated with tissue plasminogen activator followed by heparin infusion. If thrombolysis becomes more widely used its potential danger in conditions mimicking myocardial infarction must be realised (p 527)