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Correspondence

Letters to the Editor should not exceed 500 words.

Abandoned Patients

SIR,—Many long-stay hospitals contain numbers of patients who have no home, no relatives, and no visitors and are in the position of being virtually abandoned by society. In some cases relatives have failed to inform the hospital of their changed addresses so that their whereabouts cannot be traced, in others relatives are dead or unknown, as sometimes the patients have come to hospital through children's departments and other local authority services.

This is not a new problem, but where the responsibility lies for safeguarding the interest of these patients is far from clear. At present the hospital authorities who have the care of these patients act "in loco parentis" out of necessity, and often arrange for League of Friends and voluntary helpers to take an interest in the lives of these patients. The legal position of the hospital in regard to child patients in hospital who have been abandoned by their parents and to severely subnormal adults who are in a comparable position remains uncertain. It would appear not unreasonable that the local authority of the area in which the patient was permanently domiciled before admission to hospital should, in the event of the person being abandoned, accept some responsibility for the patient in hospital, as this authority would normally make provision were the patient to be discharged to the community.

The increasing life expectancy of long-stay hospital patients, the greater mobility of their families and relatives, and a growing concern about the welfare of patients in long-stay hospitals are now making the need for some guidance on this particular problem essential.—I am, etc.,

D. A. SPENCER.

Castleberg Hospital, Settle, Yorks.

Complications with I.U.D.s

SIR,—Dr. D. F. Hawkins (10 May, p. 381) suggests that the incidence of pregnancies, expulsions, removals, pelvic inflammatory disease, and perforations of the uterus among women wearing intrauterine devices may be grossly understated in published reports, including the reports of the Cooperative Statistical Program, because a not insignificant proportion of the women originally included in the study are lost to follow-up. He states that a woman who experiences serious adverse effects "does not in general return to the clinic where the device was fitted, but has recourse to a hospital with an acute gynaecological unit and resists contact for follow-up purposes."

Dr. Hawkins's concern is entirely justified. The life table method of computing cumulative rates of pregnancies, expulsions, and removals, which has been used by the Cooperative Statistical Program since its inception in 1963, is based on the implicit assumption that women lost to follow-up are subject to the same risks of pregnancy, expulsion, and removal as are those women who remain under observation after an equal period following the first insertion of the device. If this assumption is incorrect, the results could be misleading.

In order to test the hypothesis we have computed cumulative rates of pregnancies, expulsions, and removals, by reason, per 100 users during the first year of use for loop D, separately for a group of ten investigators with good follow-up, and for a comparable group of ten investigators with poor follow-up.[1] The numbers of woman-months of wearing the I.U.D. in the two groups were, respectively, 27,412 and 18,978 and the cumulative rates of loss to follow-up, during the first year of use, 3·3% and 13·1%. The figures shown under the headings L.L. (lower limit) and U.L. (upper limit) are the 95% confidence limits of the cumulative rates immediately to the left.

Type of Event	Good Follow-up			Poor Follow-up		
	Rate	L.L.	U.L.	Rate	L.L.	U.L.
Pregnancies	2·3	1·7	2·9	2·6	1·9	3·4
Expulsions:						
First	9·6	8·4	10·7	9·0	7·7	10·4
Later	3·9	3·1	4·6	3·3	2·4	4·1
Removals						
Bleeding and/or pain	8·9	7·7	10·0	11·8	10·3	13·4
Other medical	3·5	2·7	4·2	3·9	3·0	4·8
Planning pregnancy	0·8	0·6	1·3	0·9	0·5	1·3
Other personal	2·7	1·8	2·9	2·3	1·6	2·9

It can be seen that for most of the rates shown in this Table the difference between the two groups is insignificant, inasmuch as the lower confidence limit of the higher rate is below the upper limit of the lower rate. The only significant difference appears between the two rates of removals because of bleeding and/or pain, a rate notoriously susceptible to variation between investigators, and here the incidence is somewhat *higher* for the group with poor follow-up than for the group with good follow-up. These findings lend support to the underlying assumption of the life table method.

Rare complications, such as pelvic inflammatory disease with fatal outcome or intestinal obstruction following perforation of the uterus, cannot be adequately studied in a prospective investigation, even one as large as the Cooperative Statistical Program.