BRITISH MEDICAL JOURNAL

SATURDAY 24 MAY 1986

LEADING ARTICLES

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MEDICAL PRACTICE

NEWS AND NOTES

SUPPLEMENT

NO 6532 BRITISH MEDICAL JOURNAL 1986 VOLUME 292 1347-1412
BRITISH MEDICAL ASSOCIATION TAVISTOCK SQUARE LONDON WC1H 9JR.

WEEKLY. ISSN 0267-0623
ASTM CODEN: BMJOAE 292 (6532) 1347-1412 (1986)

CORRESPONDENCE

Because we receive many more letters than we have room to publish we may shorten those that we do publish to allow readers as wide a selection as possible. In particular, when we receive several letters on the same topic we reserve the right to abridge individual letters. Our usual policy is to reserve our correspondence columns for letters commenting on issues discussed recently (within six weeks) in the BMJ.

Letters critical of a paper may be sent to the authors of the paper so that their reply may appear in the same issue. We may also forward letters that we decide not to publish to the authors of the paper on which they comment.

Letters should not exceed 400 words and should be typed double spaced and signed by all authors, who should include their main degree.

Production and deployment of binary nerve gas weapons

SIR,—As doctors who are aware of the indiscriminate nature and potential for mass destruction of binary nerve gas weapons, we deplore the recent decision of the NATO Defence Review Committee (on which the UK is represented) to approve production of these weapons by the United States and their deployment in time of crisis.

In our view this decision is contrary to the 1925 Geneva Protocol, as production and readiness to deploy these weapons bring us closer to "use," which is prohibited by the Convention. Further, the production and threat of use of these weapons are contrary to articles 35 and 36 of the Second Geneva Protocol (1977), which prohibits the use of weapons which are indiscriminate and cause unnecessary suffering.

We are aware of the UK government's position that binary nerve gas weapons are for deterrence only and that NATO possession of the weapons will help in the negotiations for a treaty banning chemical weapons. We do not feel that this position is logical or reasonable, as production is just as likely to result in an uncontrollable arms race, in proliferation, and in actual use.

As all parties to the Geneva negotiations have made serious proposals for a treaty with verification procedures, we would like our government to press for an early treaty and not to give further approval to the binary nerve gas project.

The possession and threat of use of these weapons must be regarded as immoral and contrary to the spirit of the United Nations charter.

We would like to ask all health workers to take action in whatever way they can by lobbying members of parliament, writing letters to ministers, and supporting any organisation they belong to which opposes chemical weapons. The tragedy of world war I, in which hundreds of thousands of soldiers were killed or incapacitated for life by chemical weapons, must not be repeated.

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Oral contraceptives and hepatocellular carcinoma

SIR,—The Committee on Safety of Medicines has had the opportunity to see the papers by Dr J Neuberger and others (p 1355) and by Dr D Forman and others (p 1357), both kindly provided by their authors.

The authors of both papers suggest that the relative risk of hepatocellular carcinoma is increased by long term use of oral contraceptives, but the absolute risk remains very small; primary hepatocellular carcinoma in young women remains an exceptionally rare disease in the United Kingdom. The investigators have carefully considered the difficulties relating to these studies, acknowledging the need for making assumptions and qualifications about the data on which the estimates of relative risk depend.

Some data sheets for oral contraceptives already carry warnings about the possible occurrence of malignant liver tumours, and the committee is currently considering whether changes are needed in data sheets generally. The CSM will also continue to monitor the possible long term risks of oral contraceptive use in relationship to its benefit.

ABRAHAM GOLDBERG
Chairman

Committee on Safety of Medicines, London SW8 5NQ

SIR,—Dr J Neuberger and colleagues report an increased relative risk (4·4) of hepatocellular carcinoma among oral contraceptive users of eight years or more in a case-control study of living women, and Dr D Forman and others report an increased risk (20·1) in a case-control study of women dying from hepatocellular carcinoma. Assuming these results are valid, we have tried to put them in perspective by calculating the effect of the additional risk on the life expectancy of an oral contraceptive user using a model which includes all known risks and benefits of oral contraceptive use.[1]

Neither study provides information on the recency of oral contraceptive use, but the process of calculating life expectancy emphasises the importance of this. We assumed that an increased risk for hepatocellular carcinoma begins after only five years of continuous oral contraceptive use and that the risk declines by 25% in each succeeding five year interval. This seem biologically plausible, but if the risk declines immediately after discontinuing oral contraceptives, as is the case with benign liver tumours, then the long term impact would be smaller.

For women who take oral contraceptives continuously for five years the increased risk of hepatocellular carcinoma has no significant effect on life expectancy under the assumptions described above (table). Translated into meaningful terms for the user, the model suggests that the