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Correspondence

Letters to the Editor should not exceed 500 words.

Oral Contraceptives and Thromboembolic Disease

SIR,—Lieutenant-Colonel J. J. Deller (9 November, p. 391) criticizes our studies of the relationship between thromboembolic disease and the use of oral contraceptives on three grounds. First, he finds it difficult to understand why, in Inman and Vessey's study (27 April, p. 193) the proportion of contraceptive users in the group of women who had some predisposing condition and died of pulmonary embolism was only slightly greater than in the control group, while it was much higher in the group of women who died of pulmonary embolism without predisposing cause. Evidently he missed our statement that "this investigation can provide no information about the risk among women suffering from predisposing conditions." The reason was that the control series consisted of women who, by and large, were in normal health, while the women with predisposing conditions had recently undergone surgery, had had previous thromboembolic disease, or were suffering from a wide variety of chronic illnesses. We would not expect the sexual activity of these two groups of women to be comparable, and we believe that some of the predisposing conditions from which the women with thromboembolism were suffering would be regarded by their doctors as contraindications for treatment with oral contraceptives. Unfortunately it was not possible to obtain a control group of women with the same predisposing conditions among whom the use of oral contraceptives could be estimated, so that no definite conclusion on this aspect of the problem was possible.

Secondly, Dr. Deller is surprised that the number of women who died of pulmonary embolism and had not had a predisposing condition was only half the expected number for non-users, while for users it was four times the expected number. The explanation in this case is a matter of arithmetic. The method of calculation of the expected numbers required the sum of the users and non-users to be equal to the total number of women observed. Hence if the expected number of users was less than the observed, the expected number of non-users had to be greater than the observed.

Thirdly, Dr. Deller considers that the exclusion of spinsters and widows from one study and of spinsters, widows, women who were separated or divorced, and women whose physician could not be traced, from the other, was a "significant fault in the design of these studies." The fact that 27 general practitioners (5% of the total) could not be traced in Inman and Vessey's study was unfortunate but could not be avoided. The effect of excluding women for whom it was impossible to obtain the relevant information was considered in our report and we saw no reason to believe that it had biased the results.

The exclusion of patients on the grounds of marital status was, however, quite deliberate. In Vessey and Doll's study (27 April, p. 199) to have asked questions about the contraceptive habits of single or widowed women might have jeopardized the co-operation of the doctors whose patients we wished to interview. Secondly, to have included such women in either study would not have appreciably increased the yield of information about oral contraceptives, since these women form a section of the population that uses them relatively little. Our decision to exclude patients on the grounds of marital status is of no greater significance than our decision to impose age limits. It merely implies that our estimates of risk apply only to married women, just as they apply only to women in the age range 16–44 years. It may be noted also that the number of women with "idiopathic" thromboembolism excluded on the grounds of marital status was, in fact, less than 20% of the total postulated by Colonel Deller, which also included women with postoperative and other types of thromboembolism.—We are, etc.,

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Training of Surgeons

SIR,—The value of the educational content of your leading article (16 November, p. 401) on the training of surgeons should not obscure the dubious wisdom and truth (as some may think) of two or three assumptions and assertions made therein.

"That training must take priority over service" and that "senior registrars should be supernumerary" may, to some, seem to denigrate the in-service training that has always been a characteristic and an outstanding virtue of the British system. It would be interesting to know the views of the trainees themselves in this regard.

Approximate parity between the number of consultant vacancies and the number of trainees in senior registrar posts is an accepted and acceptable arrangement. That there should be three potential consultants in the pipe-line for every expected vacancy is indeed "indefensible," but that "it follows that the number of registrar training posts must be substantially fewer" is not a logical deduction. Any cut would be made at the expense of overseas applicants. The number of potential surgeons coming forward from British medical schools would not be affected. In this, and in other respects, your leading article ignores both the contribution to the National Health Service made by temporary