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CORRESPONDENCE

Correspondents are asked to be brief

Distribution and Supervision of Oral Contraceptives

SIR,—When oral contraceptives were first introduced in the United Kingdom in 1960 it was reasonable to restrict the use of these unknown and relatively powerful drugs solely to prescription by doctors. However, with 2¼m. users, with an increasing understanding of long- and short-term side effects, and with some significant reductions in dose the need now arises to review the available methods of distribution and supervision.

Oral contraceptives have proved effective in preventing pregnancy and are relatively simple to use, and the health benefits of their use almost certainly outweigh the risks of use in nearly all cases. As with all effective therapies there is a continual obligation both to use the available medical skills as effectively as possible and to review the accessibility of the therapy to those in need. Any increase in the use of oral contraceptives, by preventing unplanned pregnancies and induced abortions, will make a contribution towards further reducing maternal mortality as well as increasing the quality of life for parents and their children.

Any method of distributing oral contraceptives and supervising continued use must meet a number of needs: it must protect users against any predictable risks, it must allow for continued monitoring of side effects, especially long-term effects, so that the remaining unknowns can be answered as soon as possible, it must use the skills of the medical team—doctor, midwife, nurse, health visitor, social worker, or lay counsellor—as effectively as possible, and it must offer the maximum convenience and easiest possible access for women who wish to use oral contraceptives.

Accessibility of initial and resupply packs of oral contraceptives is one variable determining acceptance and continuation of use, and the limitation of oral contraceptives to a doctor's prescription can increase the geographical and social distance between the user and provider as well as burdening an overstretched medical service. Observation shows that prescription means different things to different doctors, varying from frequent thorough physical examination to the briefest possible interview. Variations in clinical practice may contribute to the fact that some women have a confused image of oral contraceptives. As a consequence of the present system of distribution unplanned pregnancies and induced abortion, which might otherwise be avoided by the voluntary limitation of fertility, continue.

We conclude that it would be a responsible and constructive step forward in medical practice to widen the range of those empowered to dispense oral contraceptives to include state registered nurses, midwives, and health visitors who have had some additional training in contraceptive practice. As in other circumstances where non-doctor health personnel dispense pharmacologically active compounds (or are involved in important procedures, such as delivery of a baby) the doctor would continue to supervise the service and would deal with complicated cases referred to him. We also believe in the need for the user of any method of contraception to have the fullest possible confidence in that method and suggest that any woman who wishes to see a doctor when starting oral contraceptives or during their use should continue to do so.
—We are, etc.,

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Mid-trimester Termination

SIR,—Your leading article on the use of prostaglandins for mid-trimester abortion (17 August, p. 428) is very timely since these compounds are now commercially available in several countries (including the U.K.) and are likely to be widely used. The recent reports of cervical rupture are disturbing and your article rightly emphasizes the need for carrying out second-trimester terminations in a fully equipped unit. It is estimated that $PGF_{2\alpha}$ given by the intrauterine route has been used in over 5,000 patients for the termination of late pregnancy and so far 13 cases of cervical rupture have been reported. Details of these cases are given in the table.

The reported cases of cervical rupture have several features in common: (1) Most ruptures have occurred in young primigravidae. (2) All were given $PGF_{2\alpha}$ intra-amniotically (with one exception who received a combination of PGE_2 and $PGF_{2\alpha}$). (3) All were in the second trimester of pregnancy (gestation 15-22 weeks). (4) In most cases either high doses of $PGF_{2\alpha}$ were given or additional oxytocics used.

It is just over three years since prostaglandins were first used intra-amniotically for the termination of second-trimester pregnancy.[7 8] During these years investigators have used different dose schedules in order (*a*) to reduce the injection-abortion interval and (*b*) to make the termination of second-trimester pregnancy with intra-amniotic prostaglandins a single-injection procedure. To achieve this large doses of prostaglandins have been used and often supplemented by other oxytocics (intra-amniotic urea or intravenous oxytocin). Cervical rupture could then be the result of