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SUPPLEMENT

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CORRESPONDENCE

Correspondents are urged to write briefly so that readers may be offered as wide a selection of letters as possible. So many are being received that the omission of some is inevitable. Letters should be signed personally by all their authors.

Oral contraceptives in women over 34

SIR,—Dr J A McEwan (16 August, p 433) invites comments in relation to prescribing the combined oral contraceptive pill to women over 34 years of age who have one or more of the other predisposing risk factors for ischaemic heart disease and thromboembolism which have been shown to be associated in a synergistic manner by Dr J I Mann and others (3 May, pp 241 and 245). These additional predisposing risk factors were diabetes, obesity, heavy smoking, treated hypertension, and type II hyperlipidaemia.

In their first paper Dr Mann and his colleagues showed that there was only one case of infarction where current oral contraceptive use was unassociated with any of the risk factors just listed (see table X). Dr Mann has informed me that this woman was aged 41. This fact suggests that the added risk of oral contraception due to age alone is not great. This is especially so when balanced against the risk of pregnancy in this age group, although it must be accepted that, as Dr McEwan points out, their inherent fecundity is reduced and there are other methods of contraception.

Unfortunately, however, a cohort of women is reaching the older age groups who have, as it might be said, been "spoilt" by the use of the oral contraceptive pill. They may accept an intrauterine device but then be forced to abandon that method as a result of bleeding irregularities. Their motivation to use barrier methods is likely to be poor. In view of this I believe that the evidence for an increased risk of thrombosis in healthy older women needs to be stronger before their freedom to use this method is arbitrarily restricted. It is surely premature that the US Food and Drug Administration has recommended in its revised labelling for oral contraceptives that women aged 40 and over should not take the pill; although the FDA is basing this advice largely on British data, the Committee on Safety of Medicines has apparently no plans to make similar recommendations here, although it is keeping the situation under review.[1]

What now will be the defensibility of an action brought against a prescribing doctor after the death of a woman aged more than 40 who was taking the pill in the absence of any other risk factors? This American decision is, for legal rather than medical reasons, likely to remove clinical freedom from prescribers and, more important, expose unnecessarily a considerable number of women to an increased risk of unwanted pregnancy.

This discussion does not, in my opinion, render untenable the view that was expressed by Dr M V Smith and others (19 October 1974, p 161) that the range of those empowered to dispense oral contraceptives should be widened to include nurses and others who have had additional training in contraceptive practice. Only one of the risk factors listed cannot be easily screened for by appropriate questioning and the measurement of weight and blood pressure plus urine testing. Provided such non-medical workers were well trained (and that is the important point) they could be as safe as or safer than most current prescribers. Type II hyperlipoproteinaemia is rare, and routine screening may not be feasible at the present time. But a positive family history of myocardial infarction or of any form of thrombosis in a young relative may provide a clue to its presence and should not be missed by appropriate questioning. Where the facilities exist I believe that all those with such a family history, all women over the age of 40, and many women with the other associated risk factors (particularly if in combination) should have a plasma cholesterol examination done at the first