Missed pill conception: fact or fiction?

Sin—Following the correspondence (13 July, p 136) on the paper by MacGregor and others (18 May, p 1474) we would like to express a cautionary note. We would agree with the points expressed about ovulation folliculogenesis, which occurs to a similar extent in the first seven days of spontaneous cycles as in the seven pill free days of combined oral contraceptive cycles. Some women seem less susceptible to gonadotrophin suppression than others during their pill taking days. These points were made some considerable time ago by endocrine assessment.4 More recently ultrasonographic evidence for this has come from Meigou and others and Van der Vange et al (personal communication) and from our own results so far. It remains also to establish what potential for ovulation these ultrasonographically demonstrated ovary cycles have. There are considerable difficulties in the design of research protocols to show this.

However, the suppression of gonadotrophin induced ovarian folliculogenesis is not the only mode of action of the combined oral contraceptive pill. Ancillary contraceptive effect is provided by impotent cervical mucus, which inhibits sperm transport, and by rendering the endometrium unfavourable for implantation. Hence, follicular development cannot be the only factor implicated in the mechanism of pill failure and any study of the latter must ideally incorporate concurrent endocrine variables, ultrasonographic assessment, and assessments of cervical mucus.

Recommendations to women who inadvertently miss pills must inevitably, for the time being at least, be largely empirical. However, within the constraints of the data available, the following advice should be given. If the omission of a pill served to extend the pill free period and hence the time available for folliculogenesis and effective sperm transport, the next pack of pills should be started without a break at all. Arbitrary rules for the prolonged use of barrier contraception in the women who occasionally omit their pills have little scientific foundation, their planning during the time of omission and until the progestogen effect on the cervical mucous has become manifest. From our published data and further studies in progress the current barrier effect persists even with one or two days of pill omission. The time taken for the development of these changes during a course of pills needs to be firmly established.

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References


Smoking, sugar, and inflammatory bowel disease

Sin—In their paper on smoking, sugar, and inflammatory bowel disease Dr J R Thoroton and others (15 June, p 1786) emphasize again the recently reported relation between smoking and inflammatory bowel disease.9 The conclusion, however, that smoking may confer some protection against ulcerative colitis may still be premature and needs additional evidence.

We would like to report our observations in 93 patients with ulcerative colitis. The control group consisted of 177 consecutive patients matched for age and sex from an orthopaedic clinic. Seventy one (78%) of the 93 patients with ulcerative colitis never smoked compared with 112 (68%) of the control group (p<0.05). Also significant was the difference among smokers: nine (9%) patients with ulcerative colitis compared with 39 (22%) in the control group (p<0.05) smoked between a half and two packs of cigarettes daily.

Surprisingly, in the group of ex-smokers (those who stopped smoking at least one year before the onset of the disease) we found a lower morbidity still in the patients who never smoked. Does therefore, smoking in the past confer some protection against the development of ulcerative colitis? Is there any relation between smoking and the expression of the disease? Apparently not. In our series 71/6 (74%) of patients with total colitis were non-smokers compared with 60 (76%) of 79 who had proctitis or left sided colitis.

Like Dr Thoroton and others, we found smoking to be more common among our 10 patients with Crohn's disease than in the control group.

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