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The Contraceptive Pill—Current Status

Although it is only 16 years since the contraceptive pill was first reported,[1] more direct research, scientific evaluation and newsprint have probably been expended on it than on any other medical substance ever introduced. Some 14 million women are estimated to be taking contraceptive pills.[2] It is therefore timeous to re-evaluate the current status of this method, and the responsibility of the medical practitioner in the prescription thereof.

That the pill is effective is not denied; the most popular form prescribed, namely the combined oestrogen/progestogen mixture, produces virtually a 100% success rate, and any pregnancy on such medication is bound to be due to patient failure. The early high-dosage forms introduced were proved to have serious side-effects, both major and minor, and this led to significant changes in the form and content of the pill, to the extent that the spectrum of pills in popular clinical use today varies considerably from the original pill introduced by Garcia *et al.*[1]

A major example of such change is demonstrated in the relationship between oral contraceptives and the incidence of thrombo-embolism. In 1967 the British Medical Research Council first published findings relating the use of the pill to thrombo-embolism. In 1970[3] a statement was issued by the Committee on Safety of Drugs, calling for a reduction in the oestrogenic component of combined oral contraceptives. This has been done, and subsequent follow-up reports have substantiated the benefits obtained. Moreover, forms of the pill were introduced in which progestogen only was administered, the oestrogen being excluded, and although less effective, they have been relatively well accepted in the current spectrum of pills available.[4]

There have been anxieties about other major problems such as liver dysfunction, carcinoma of the cervix, diabetes, hypertension and other rarer diseases. These have generally been disproved or been shown to be of little significance.

A common cause for concern among prospective pill-takers is the question of subsequent infertility after taking the pill. The largest series on post-pill amenorrhoea has been reported by Shearman and Smith,[5] a total of 96 patients having been gathered between the mid-1960s and 1972. The incidence is probably low, and the subsequent outcome generally good, the cause probably being a failure by the hypothalamus to secrete gonadotrophin-releasing hormone. It is of interest that the length of pill-taking does not seem to matter in regard to development of the amenorrhoea, nor does any particular pill mixture, nor any history of irregularity of menstrual cycle. Although it is a cause for concern, the condition does not justify withholding this contraceptive method from the population requiring it.

Numerous minor side-effects have been claimed. For example, in the present issue the relationship between headache and the oral contraceptive is discussed.[6] However, the recent report from the Royal College of General Practitioners,[7] based on observations on 46 000 women, found no side-effects that had not been reported in earlier studies. The risks of the pill have thus been fairly well defined, and both mortality and morbidity can now be estimated fairly accurately.

There is one major conclusion to be drawn from the all-clear on safety given to the pill by the RCGP report, namely, that a variety of metabolic abnormalities and adverse effects may follow its use, albeit rarely, but despite this the matter is now decided by women themselves, who have accepted the method and a certain amount of inherent risk, and nonetheless request it. The onus is therefore on the medical profession to select the most suitable type of pill for each type of patient. An attempt must be made to assess the risks in specific individuals, and to prevent prescription of oral contra-

ceptives for those who might be endangered by them. For example, oestrogenic type females should be given a more progestogenic type of pill and *vice versa*. The majority of patients would be best suited by low-dose combination pills. Where contra-indications to oestrogens exist, a progestogen-only pill is recommended, or a non-pill alternative. Patients with medical contra-indications to the pill, such as tendency to or history of thrombosis, liver dysfunction, breast tumours, etc., should be warned against the pill. Finally, all patients on the pill should be seen at least once a year; the older patient on the pill should preferably be monitored every 6 months, and should have at least a clinical examination with blood pressure recording, urinalysis, and cervical smears. Constant vigilance is likely to improve the safety of what is now a well-accepted and excellent method of family planning and population control.

1. Garcia, C. R., Pincus, G. and Rock, J. (1958): Amer. J. Obstet. Gynec., **75**, 82.
2. Leading Article (1974): Brit. Med. J., **1**, 517.
3. Statement by the Committee on Safety of Drugs (1970): *Ibid.*, **1**, 231.
4. Leading Article (1972): *Ibid.*, **2**, 190.
5. Shearman, R. P. and Smith, I. D. (1972): J. Obstet. Gynaec. Brit. Cwlth, **79**, 654.
6. Utian, W. H. (1974): S. Afr. Med. J., **48**, 2105.
7. Royal College of General Practitioners (1974): *Oral Contraceptives and Health*. London: Pitman Medical.

Tweedehandse Kennis

In die Engelse inleidingsartikel in hierdie uitgawe noem ons die verskeidenheid mondelinge voorbehoedmiddels wat deesdae beskikbaar is, elk met sy besonderse werking en eienskappe. In wese is hulle eenders, maar dit is tog belangrik dat iedere pasiënt noukeurig beoordeel moet word sodat die preparaat wat die beste vir haar partikuliere behoeftes sal wees, uit die magdom wat op die mark is, gekies kan word. Hoe word die regte een gekies? Die noukeurige dokter sal die eienskappe van die pil wat hy voorskryf goed ken, en sal weet hoe om vas te stel welke kombinasie van hormone vir die individu geskik sal wees, maar waar vind hy die kennis? Luister hy na die advies van kollegas of kies hy kortpad en aanvaar hy die reklamepraatjies van die betrokke farmaseutiese firma se verteenwoordiger? Miskien lees hy artikels in wetenskaplike tydskrifte—'n prysenswaardige metodiek, maar dit is uitsonderlik dat die oorspronklike bron tesame met die ander literatuur geraadpleeg word. Ons verwys na die inligting wat deur die firma self beskikbaar gestel word. Nie net die samevattende gegewens op die etiket of selfs op die pamflet in die verpakking nie, maar die volledige beskrywing wat die lang paadjie boekstaaf wat die navorsers moes deurloop alvorens die preparaat bemark kon word. Kom ons laat hierdie gedagte eers daar en breek weg van die handelswêreld om na die kliniese wetenskap te kyk.

Almal dra kennis van die evolusieleer van Darwin—daardie stellings wat hom soveel jare besig gehou het en tot beroemdheid (en in sekere eietydse kringe berugtheid) gelei het. Ons praat van evolusie en ons redeneer daaroor, maar hoeveel van ons het al Darwin se geskrifte self gelees? Ons bedoel nie boeke oor Darwin se stellings nie en ook nie opsommings van sy lywige werke nie; ons praat van die oorspronklike publikasies — *The Origin of Species* en dies meer. Fröhlich se sindroom is 'n bekende entiteit, maar ons wonder of daar baie geneeshere, selfs spesialiste op die gebied van die endokrinologie, is wat die oorspronklike publikasie van Fröhlich gelees het; en Kimmelstiel-Wilson se artikel of selfs die baanbrekerspublikasie van Banting en Best. Menige mediese studente wat hul lektore die loef wou afsteek, het al ontdek dat 'n gesnuffel in die mediese biblioteek om sulke geskrifte te gaan naslaan, 'n baie oortuigende argument in die klaskamer kan verskaf. 'Maar professor, soos Von Recklinghausen in sy oorspronklike artikel gesê het . . .' So 'n wysneus is beslis nie populêr nie, juis omdat dit 'n onomstootbare feit is dat menige van hierdie welbekende sindrome deur die jare verwring en afgewater geraak het, sodat die entiteit waarvan ons vandag praat nie meer presies ooreenkom met wat die eerste outeur beskryf het en waaraan sy naam geheg is nie.

Ons aanvaar die kennis wat tweedehands aan ons opgedis word en ons bou met dankbaarheid daarop voort deur die nuwe denke en navorsing oor die onderwerp te lees of deur self te gelegener tyd nuwe navorsing by te dra, maar die oorspronklike, die oerbron, word maar selde geraadpleeg, en om terug te kom tot die voorbehoedende pille, die oerbron in die geval van geneesmiddels is die geskrifte van die farmaseutiese firmas self. Van daar kan ons uitbou, maar die korrekte benadering alvorens 'n nuwe middel voorgeskryf word sal wees om eerstens die kennis van die fabrikante en hul navorsers onder die knie te kry.