cepting the pills discontinued by the end of the sixth cycle and the mean of continuance after one year is 68 per cent. Acceptance rates vary enormously from country to country; in Ceylon, a study found 76 per cent continuing after a year, and in Bombay over 71 per cent. These were roughly the same continuation rates reported from developed countries.

Side Effects

The most common side effects include nausea, break-through bleeding, weight gain, headache, bloating and breast tenderness. These side effects generally disappear by the fourth cycle and appear to be significantly reduced with the lower doses of the compounds currently available. Fertility is promptly restored following cessation of the medication. No causal relationship between the current oral contraceptives and any type of malignancy has been reported. However, the World Health Organization declares it is accepted practice to withhold oral contraceptives containing estrogen from pre-menopausal women with diagnosed breast cancer.

Because in occasional cases pre-existing fibromyomata have been observed to enlarge during administration of these drugs, the medical Committee of Planned Parenthood Federation of America has recommended that pelvic examination be done before the initiation of treatment and again six months later.

The question of a possible causal relationship between the use of oral contraceptives and the occurrence of thrombo-embolic phenomena has been raised. Three recent responsible British studies have shown a slight increase in thrombo-embolic accidents and fatalities among users of oral contraceptives. In one of these British studies it was found that the risk of incurring thrombo-embolic disease was increased nine times for pill users from five per 100,000 to 47 per 100,000. Another study found that the risk of mortality from pulmonary embolism or cerebral thrombosis among women 20-34 increased from 2 per million to 15 per million. Among the age group of 35-45, however, the risk is increased from 5 per million to 39 per million. The World Health Organization, taking note of these studies, points out that the risk among pill users of incurring thrombo-embolic disease, or dying from it, "appears to be small in comparison to the overall risk incurred by planned and unplanned pregnancy." Nevertheless, the World Health Organization cautions that a history of thrombo-embolic disease should be considered "a contraindication to the use of steroid contraceptives," and the Food and Drug Administration recently required that all Pill manufacturers revise their labeling so as to inform U.S. physicians of the British findings, and advise them to discontinue the use of the pill should thrombophlebitis, cerebro-vascular disorders, pulmonary embolism or retinal thrombosis occur or be suspected.

Masculinization of the female fetus causing partial fusion of the labia and/or hypertrophy of the clitoris has been observed in cases where progestins were given in large doses during pregnancy for the purpose of preventing threatened abortion. No fetal masculinization has been reported resulting from the contraceptive use of these compounds.

Intrauterine Devices

(See attached product list and p. 15 for related readings.) The recent development (1959) of new intrauterine devices has reawakened medical interest in this method of conception control.

The early intrauterine devices, such as the Gräfenberg ring, fell into disrepute because of the fear of complications. The development of new and relatively inert materials such as plastic and stainless steel along with the urgent need for a simple, inexpensive, effective method to prevent conception, independent of coitus and not requiring sustained motivation, was responsible for the revival of interest. Intrauterine devices have received the most careful and extensive clinical evaluation of any contraceptive method to date. Statistics from the National Committee on Maternal Health are currently available for over 27,600 women with a record of use in excess of 477,000 woman-months. On the basis of these results the Medical Committee of Planned Parenthood Federation has found the present "open" devices are both safe and highly effective.

Insertion

Insertion of the plastic and some stainless steel devices into the uterine cavity is accomplished by loading the device into a slender plastic tube which is then introduced through the cervix. A plunger is inserted into the tube and the device is pushed into the uterine cavity. The tube is withdrawn, leaving the device in the uterus, where it rapidly resumes its preinsertion shape. The stainless steel ring is inserted by being stretched over a forked instrument. With most patients cervical dilation is not required for insertion of either the plastic or stainless steel devices. Insertion during the last one or two days of a menstrual period is preferred because introduction is easier at this time, an existing pregnancy is not threatened, and post-insertion spotting, which occurs in a significant percentage of patients, is less likely to alarm the patient. Another favorite time for insertion is at the post partum examination. It was previously believed that intrauterine contraception was more suitable for the parous than the nulliparous women.