and a perspective to these figures, they compared the death rate from blood clots to deaths from all conditions associated with pregnancy and with deaths from motor accidents.

They noted that among the younger women 22.8 of every 100,000 healthy married women would die as a consequence of pregnancy, compared with 1.5 of every 100,000 women who would die as the result of a fatal clot associated with the pill.

Among the older group, 57.6 of every 100,000 women would die as a result of pregnancy, compared with 3.9 who would die of a clot associated with the pill.

DEATH RATES PER 100,000 HEALTHY MARRIED FEMALES

Age	20 to 34	35 to 44
Thrombosis, lungs or brain pill users	1.5	3.9
Thrombosis, lungs or brain nonpill users	.2	.5
Pregnancy, all causes	22.8	57.6
Motor accidents	4.9	3.9

These data show that the risk of death from clots among the younger group of pill users is about one-fifteenth the risk of death from pregnancy and about one-third the risk from auto accidents.

I recognize that fact that not all women who will cease the pill will necessarily become pregnant. But were all the women to switch to the next two most effective contraceptive methods—the Intrauterine Device (IUD) and the diaphragm—the pregnancy rates would be two to four times higher with the IUD and 10 to 30 times higher among users of the diaphragm (9). Therefore, the risk of death would rise proportionately. To further complicate the picture, use of the IUD also carries a risk of death, of about 1 or 2 per 100,000 (10).

I should like to point out also that the death rate associated with pregnancy is even higher in the U.S. than in Britain, especially among poor women (11).

These are some of the considerations that must be weighed when assessing the safety of oral contraceptives.

In my interpretation of the published data, the only other established fact in this area is that other serious adverse reactions may occur in occasional patients. The more common are high blood pressure, headache, depression, interference with vision, and nervousness. Usually, these side effects are reversible and disappear if contraceptive pills are discontinued promptly. These rare adverse affects are well known to physicians and appear in the labelling of the drugs.

Now, as to metabolic changes: I recognize that fact that there are extensive changes in the body chemistry of some women taking the pill. But no proof exists in the medical literature, nor has any been presented before this Committee, that these changes are or will be harmful. Furthermore, in some patients the changes revert to normal while they continue on the pill; in others, when the oral contraceptive is discontinued.

In addition to these facts, there are *conjectures* about the pill. In underscore *conjectures*. First, that it may be carcinogenic, cause cancer.

Dr. Roy Hertz has stated before this Committee that to date *no* case of cancer in either a monkey or in a human being can be attributed to the pill. Many physicians and investigators believe that the fact that cancer can be produced in five species of animals (rodents and one breed of dog) by relatively huge daily overdosages with estrogen, comparing their body weight with that of a woman, produces little evidence that the contraceptive pill is likely to cause human cancer.

Dr. Hertz is concerned that the hormone, estrogen, a component of the pill, may cause cancer in two target organs in women on the pill: the breast and uterus. This is *conjecture*, by Dr. Hertz' own testimony.

It is of interest, I believe, that the American Cancer Society reports that there has been no increase in breast cancer mortality in the decade since the pill has been in use in the U.S. (12). This does not negate the possibility there may be an increase in the future in breast malignancy from the pill, but I believe the *fact* cited above deserves mention along side of Dr. Hertz' conjecture.