

TABLE 4.—TREND OF MORTALITY FROM PULMONARY EMBOLISM AND INFARCT (I.C.D. NUMBER 465) FOR WHITE PERSONS AGED 15-64 BY SEX, UNITED STATES, 1960-1966.

Age class	Sex	Regression coefficient b	Standard error of b	Pr (b=0)
15 to 24.....	M	+. 1393	. 0428	<. 025
	F	+. 1132	. 0386	<. 05
25 to 34.....	M	+. 0340	. 0183	N.S.
	F	+. 1340	. 0374	<. 025
35 to 44.....	M	+. 0855	. 0157	<. 005
	F	+. 3119	. 0225	<. 005
45 to 54.....	M	+. 0756	. 0206	<. 025
	F	+. 0951	. 0244	<. 025
55 to 64.....	M	+. 0690	. 0148	<. 02
	F	+. 0753	. 0116	<. 005

See footnote to table 1 for interpretation of b and Pr (b=0).

TABLE 5.—DIFFERENCES IN SLOPES (B) BETWEEN FEMALES AND MALES, AND THEIR STANDARD ERRORS, FOR I.C.D. 465 (PULMONARY EMBOLISM AND INFARCT)

Age class	Difference in slope (f-m)	Standard error of difference
15 to 24.....	-. 0011	. 0453
25 to 34.....	+. 0515	. 0330
35 to 44.....	+. 0629	. 0299
45 to 54.....	+. 0241	. 0208
55 to 64.....	-. 0178	. 0119

References

1. Markush, R. E. and Seigel, D. G. Oral Contraceptives and mortality trends from thromboembolism in the United States. Amer J Pub Health 59:418, 1969.
2. Vessey, M. P. and Weatherall, J. A. C. Venous thromboembolic disease and the use of oral contraceptives. Lancet 2:94, 1968.

C. TRENDS IN MORTALITY FROM CEREBROVASCULAR DISEASES

Gerald R. Greene, M.D.

The temporal analysis of cerebrovascular mortality consisted of a comparison of trends and ratios of white male and female death rates from these causes singly and combined (rubrics 330-334) from 1956 through 1966. Five ten-year age groups (15-64) were studied over this period. Numbers of deaths attributed to specific causes were taken from the annual publications of mortality data for the United States.

Oral contraceptives came into general use in 1961 and their use increased rapidly thereafter. If they are causing some of the deaths from cerebrovascular disease, female death rates from this cause might have risen more sharply than male death rates in the child-bearing age range, depending upon the independent factors affecting male mortality from these causes. However, no specific classification exists for death from these conditions occurring during pregnancy or the puerperium. Thus, if such deaths are included in the rubrics studied, a rise in the female death rates directly attributable to the oral contraceptives may be concealed by a falling birth rate and a decrease of central nervous system complications attributable to pregnancy and the puerperium.

Mortality from these combined causes (rubrics 330-334) declined over the ten-year period, as did intracerebral hemorrhage (rubric 331), which forms the majority of all deaths from this group. Rates in the age group 25-34 became higher for females than for males in 1965 and 1966 for the first time. This crossover is possibly significant if one assumes that deaths from cerebral embolism or thrombosis are often misclassified as other cerebrovascular deaths and may have been included in the rubric 331.

Death rates resulting from subarachnoid hemorrhage (rubric 330) rose