or at any time during the six months preceding the terminal illness. Checklists of the proprietary names of the various preparations used as oral contraceptives were provided.

In addition to providing details concerning the fatal case each general practitioner was also requested to give information for comparative purposes about the age, marital status, parity, and current use of oral contraceptives of certain other women in his practice. It was thought that, since considerable demands had already been made on his time, close age and parity matching between the dead woman and these control subjects would not be possible. An extensive search of the practice records would often be involved, in particular when the woman who had died had borne many children.

The procedure for obtaining controls was therefore very simple. Each doctor was asked to locate in his files the position which would have been occupied by the late patient's records and which was usually still occupied by records relating to other members of her family. Moving first forwards and then backwards from that position, the doctor selected the first two sets of case notes encountered relating to women aged 15 to 44 years. Irrespective of whether or not the doctor had all the necessary information about these subjects, they were accepted as controls.

Subsequent experience showed that this procedure of selecting two controls at each interview was yielding too few subjects of high parity. Therefore for interviews concerning patients who died after 1 July 1966 four to six controls were obtained at each interview and the selection was also limited to women who were married.

In this way information about 1,133 married control subjects aged 20 to 44 years was collected.[2] Of these, 17 were known to be pregnant, 28 were of unknown parity, and there was no record of whether or not a further 90 were using oral contraceptives. These 135 controls were omitted from the analysis.

ASSESSMENT

Many conditions such as prolonged immobility, recent surgery, hypertension, and diabetes mellitus must be regarded as predisposing towards some types of thromboembolic disease. Each case history was therefore carefully examined for evidence of the presence of these or other conditions which might have contributed to the terminal illness. On receipt of each completed questionary the data concerning the patient's age, parity, and drug history were separated from the remaining information to avoid any bias in the subsequent assessment. Each case history was then considered independently by three assessors and placed in one of the following categories:

Class A.—Patients with no known predisposing conditions.

Class B.—Patients with known predisposing conditions who were neither pregnant nor in the puerperium.

Class C.—Patients who were pregnant or had been delivered during the month before the onset of the terminal episode.

At subsequent conferences it was found that major disagreement between the three assessors was unusual, and in every case it was possible to reach agreement on classification.

RESULTS IN CONTROL SUBJECTS

Table I shows the pattern of use of oral contraceptives by the 998 control subjects retained in the analysis, classified by age and parity. Among women aged 20 to 24 years there was a steady rise in the proportion using oral contraceptives from 9% of those who had never borne children to 44% of those who had borne three or more. The pattern was similar for women aged 25–34 years, though at a slightly lower level throughout the parity range. Among those aged 35–44 none of the 40 nulliparous women were using oral contraceptives and the proportion among those who had borne fewer than four children was uniformly low.

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[2] Controls aged 15–19 years were discarded, as none of the deaths studied occurred in that age group.