

TABLE III.—DIAGNOSES OF CONTROL PATIENTS

Disease group	Diseases or operations included	Number of patients
cute medical conditions (19)	Kidney or bladder infection.....	7
	Pneumonia or pleurisy.....	3
	Spontaneous pneumothorax.....	2
	Pyrexia of undetermined origin.....	2
	Others.....	5
cute surgical conditions (46)	Appendicitis.....	27
	Abdominal pain undiagnosed.....	8
	Acute cholecystitis.....	5
	Renal colic.....	2
	Quinsy.....	2
elective surgery (51)	Others.....	2
	Excision of lipoma, ganglion, etc.....	11
	Excision of thyroid adenoma (euthyroid patient).....	8
	Herniorrhaphy.....	8
	Tonsillectomy or other E.N.T. operation.....	8
All diseases.....	Haemorrhoidectomy or anal fissurectomy.....	7
	Others.....	9
		116

TABLE IV.—AFFECTED AND CONTROL PATIENTS CLASSIFIED BY USE OF ORAL CONTRACEPTIVES DURING MONTH BEFORE ONSET OF DISEASE EPISODE (OR DURING MONTH BEFORE HOSPITAL ADMISSION IN CASE OF PATIENTS UNDERGOING ELECTIVE SURGERY) (PERCENTAGES SHOWN IN PARENTHESES)

Diagnostic group	Number of patients—oral contraceptives		All women
	Used	Not used	
thromboembolism.....	26 (45)	32 (55)	58 (100)
control.....	10 (9)	106 (91)	116 (100)
Both groups.....	36 (21)	138 (79)	174 (100)

$\chi^2=28.7, n=1, P>0.001$.
Note.—The normal χ^2 test is likely to overestimate the probability of obtaining such extreme results by chance, as it fails to take account of the way in which the affected and control patients were matched. A test suggested by Professor J. J. Finney (personal communication), in which the results for each "set" of cases are scored separately, gives: $t=5.3, =57, P<0.001$.

able in respect of their country of origin and religion, the social class of their husband, and the interval between the birth of their last child and the onset of the current episode of disease. Differences were, however, recorded in the frequency of previous thromboembolic disease, the distribution of obesity, and the prevalence of smoking.

Altogether 26 patients reported previous attacks of superficial or deep vein thrombosis or pulmonary embolism—18 during pregnancy or the puerperium and 8 at other times when oral contraceptives were not being used. Table VI shows that the proportion of affected patients who reported previous attacks (36%) was significantly higher than the proportion of control patients (4%). Among the affected patients the proportion was approximately the same irrespective of the subsequent use of oral contraceptives. This was unexpected because many doctors regard a history of thromboembolism as a contraindication to the use of this type of contraceptive.

One hundred and forty-eight patients had never had a previous attack of thromboembolism, and in these women also the use of oral contraceptives was significantly more frequent in the affected group (17 out of 37, or 46%) than in the control group (8 out of 111, or 7%). In these women the prevalence of varicose veins—determined by the woman's history—was approximately the same in both the affected patients and the controls (19 and 24% respectively), and only 3 of the 17 affected women who used oral contraceptives were aware of ever having had varicose veins. These data therefore contradict Rivlin's (1967) suggestion that oral contraceptives produce phlebitis only when varicose veins are present.