Coupled with the editorial by Tony Noble arguing against the routine postnatal examination at six weeks,[5] this concern about initiating contraception before the earliest likely ovulation suggests that the optimum time for a routine postnatal appointment is at or just before four weeks. This should be seen as a safety net for contraception, since the subject is much better raised during the third trimester, at around 30 weeks' gestation, and discussed again with the woman during the postpartum home visit at around 10 days. I have suggested to both the Royal College of Obstetricians and Gynaecologists and the Royal College of General Practitioners that these recommendations should be discussed with a view to becoming the colleges' official policy.

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1 Brown R. Wrong advice on postpartum contraception. *BMJ* 1993;307:937. (9 October.)
2 O'Brien MD, Gilmour-White S. Epilepsy and pregnancy. *BMJ* 1993;307:492-5. (21 August.)
3 Guillebaud J. Contraception and sterilization. In: Turnbull A, Chamberlain G, eds. *Obstetrics*. Edinburgh: Churchill Livingstone, 1989:1135-52.
4 Cronin TJ. Influence of lactation upon ovulation. *Lancet* 1968;ii: 422-4.
5 Noble T. The routine six week postnatal vaginal examination. *BMJ* 1993;307:698. (18 September.)

### Women rarely ovulate before day 36

EDITOR,—On reading the advice on postpartum contraception in M D O'Brien and S Gilmour-White's article on epilepsy and pregnancy[1] we, like R Brown,[2] reached for our pens, convinced that it could not be accurate. But evidence that women require contraception before four weeks post partum is hard to find. In their study of 200 women Perez *et al* found that none ovulated before day 36.[3] More recent studies do not provide evidence that ovulation occurs much before this. Allowing that sperm survive for around five days, the Family Planning Association advises that oral contraception should be started 21 days post partum.

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1 O'Brien MD, Gilmour-White S. Epilepsy and pregnancy. *BMJ* 1993;307:492-5. (21 August.)
2 Brown R. Wrong advice on postpartum contraception. *BMJ* 1993;307:937. (9 October.)
3 Perez A, Vela P, Masnick GS, Potter RG. First ovulation after childbirth—effect of breast feeding. *Am J Obstet Gynecol* 1972;114:1041-7.

## Pneumococcal vaccine and splenectomy

EDITOR,—I wish to respond to H A Deodhar and colleagues as they refer to my practice and my patients in their lesson of the week.[1] I have been a consultant haematologist at the Royal Cornwall Hospital since 1986. I have referred many patients for splenectomy. I and my surgical colleague saw each patient. All the patients were counselled about the reason for splenectomy and the risk of postoperative complications. All were given an information leaflet (available on the ward) entitled "Instructions for post-splenectomy patients," which detailed the risk of infection after splenectomy and what to do in the event of fever or infection and advised on prophylaxis against infection (particularly malaria) for travel abroad. All patients received pneumococcal vaccine before surgery and began prophylactic penicillin treatment. Finally, all received a card indicating that they had no spleen and providing details of prophylaxis against infection.

Colleagues involved in the care of my patients were informed of this policy, and the patients' general practitioners were advised of the risk of infection. This is my standard practice. None of my patients has died of overwhelming sepsis after splenectomy.

I was not in a position to institute hospital policy, but my practice was known by everyone who worked with me. Deodhar and colleagues' statement that "we do not know what advice—if any—they had been given" is unfair.

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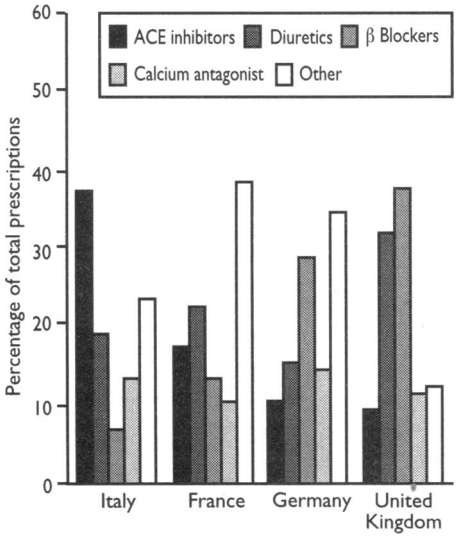
1 Deodhar HA, Marshall RJ, Barnes JN. Increased risk of sepsis after splenectomy. *BMJ* 1993;307:1408-9. (27 November.)

## Market penetration of new drugs

### Compare Britain with other national markets

EDITOR,—The article by H McGavock and colleagues on patterns of drug prescriptions in Northern Ireland[1] was interesting but flawed in its conclusions. It must be remembered that pharmaceutical companies pursue independent lines of research and usually specialise in therapeutic groups to ensure that prescribers have a range of products to choose from to meet individual patients' requirements. However, it is not always the first medicine in the field which continues to be or, in medical terms, should be the market leader. For example, among $H_2$ receptor antagonists, the second poduct, Zantac (ranitidine), outsold the first product, Tagamet (cimetidine) both in Britain and worldwide. Among β adrenergic receptors, the tenth product, Tenormin (atenolol), became the British and world market leader. What McGavock and colleagues seem to be advocating is that once the first product in a class is launched there is no need for others—a situation that would lead to therapeutic stagnation.

The other problem with McGavock and colleagues' study is that it does not include any international comparisons, nor does it take into account therapeutic shift. Thus, while use of a particular drug may increase modestly in Britain, its use in other European countries may be far greater. The figure shows the prescribing pattern for products for hypertension in Italy, France, Germany, and Britain in 1989-90. Britain was the lowest prescriber of angiotensin converting enzyme inhibitors in terms of percentages of patients being treated for hypertension. Further examples of low uptake of new medicines were described earlier this year (J P Griffin, European Federation of the Pharmaceutical Industry Association general assembly conference, Salzburg, 24-6 May 1993). It would be better if studies like McGavock and colleagues' made comparisons with other national markets. This would substantially reduce the danger of basing generalisations on too few data.




*Prescribing pattern for drugs for hypertension in 1989-90*

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1 McGavock H, Webb CH, Johnston GD, Milligan E. Market penetration of new drugs in one United Kingdom region: implications for general practitioners and administrators. *BMJ* 1993;307:1118-20. (30 October.)

### ACE inhibitors prescribed for heart failure

EDITOR,—While the benefits of angiotensin converting enzyme inhibitors in hypertension compared with more traditional treatment may be as yet unproved, their benefits in heart failure are now well established. The translation of trial data into prescribing practice could therefore account for much of the increased prescribing of these drugs between 1988 and 1991 reported by H McGavock and colleagues.[1] With an estimated prevalence of heart failure of at least 0·4%, there might be at least 6400 patients in Northern Ireland with heart failure. If all these patients were taking angiotensin converting enzyme inhibitors there would be almost 200 000 daily doses taken each month. Even if some patients with heart failure could not take these drugs, the overall prescribing of 240 256 defined daily doses each month for all indications does not seem excessive to me.

Although we do not know the indications for prescribing, accusing doctors of making unjustifiable changes in medical practice may be unjustified on this basis. Perhaps we should congratulate the drug industry on successfully disseminating knowledge about the substantial advance that has been made.

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1 McGavock H, Webb CH, Johnston GD, Milligan E. Market penetration of new drugs in one United Kingdom region: implications for general practitioners and administrators. *BMJ* 1993;307:118-20. (30 October.)

### Increased prescribing may be appropriate

EDITOR,—H McGavock and colleagues describe prescribing rates of three drug classes in Northern Ireland during 1988-91 and suggest that doctors prescribe in an "inappropriate and wasteful" way.[1] The limitations of the data make the conclusions of the paper unsound and might lead to inappropriate actions by general practitioners and administrators, who were the explicit target audience for the paper.

The reported changes in overall prescribing are open to several interpretations that include doctors overprescribing now, as the authors imply, or previous undertreatment of patients. The observed increase in prescribing angiotensin converting enzyme inhibitors could be an appropriate response to evidence of improved survival[2] or symptomatology[3] in at least some patients with heart failure who receive these drugs. The increased prescribing of $H_2$ antagonists may also be appropriate. Following the change to medical treatment of peptic ulcer, an increase in the numbers of patients who relapse can be expected. Thus, the number of patients who have active peptic ulceration and who require further drug treatment can be expected to increase. Whether the increase in prescribing $H_2$ antagonists during 1988-91 exceeds the expected increase is unclear from the data reported.