lieve nevertheless that one should not abandon the buffy coat smear since it can be a very rewarding procedure.

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The Reply:

Although I have no personal experience with buffy coat smears of bone marrow aspirates for detection of metastatic carcinoma, it seems likely that this technic may increase the diagnostic yield of simple bone marrow aspiration. However, the difficulties in accurately identifying tumor cells in Wright stained smears of bone marrow have been well documented [1]. In my view, bone marrow biopsy with the Jamshidi needle remains the technic of choice for detecting metastatic disease to the bone marrow because of the large volume of tissue examined and the ease of identifying infiltration by metastatic cells.

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ORAL CONTRACEPTIVES AND MYOCARDIAL INFARCTION IN SLE

To the Editor:

In "The Bimodal Mortality Pattern of Systemic Lupus Erythematosus" (*Am J Med* 60: 221, 1976), Urowitz and colleagues portrayed the role of myocardial infarction and atherosclerosis in the death of five patients 8.6 years after the onset of systemic lupus erythematosus (SLE). One coronary risk factor was overlooked. Three of the four female patients were premenopausal. Since patients with SLE are not generally good risks for pregnancy in their thirties, one wonders if these women used or had used oral contraceptives. Recent investigations have clearly shown that use of oral contraceptives is a risk factor independent of and additive to other risk factors for fatal and nonfatal myocardial infarction in women aged 30 to 44 years [1,2]. In view of the authors' speculation about the role of corticosteroids in the development of arteriosclerosis in these patients with SLE, the omission of information about other steroids with known associated risk of myocardial infarction in premenopausal women is striking. Does this represent yet another example of the unfortunate reality that many patients do not consider oral contraceptives as medication and hence fail to report it, or that too many physicians fail to inquire into this aspect of the patient's history?

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The Reply:

Dr. Hoch is indeed correct that oral contraceptives in our patients with SLE could be yet another risk factor for myocardial infarction. However, none of the four women in the "late-death group" were taking these drugs. Even before the reports cited by Hoch, we inquired about oral contraceptives in the routine protocol used in our lupus clinic because of the implication that these drugs induced hypertension [1,2] and perhaps SLE itself [3–5].

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GRAPHING THE GALLBLADDER: CORRECTION

To the Editor:

The clinical pathologic conference "Fever, Obtundation and Acute Renal Failure" (*Am J Med* 59: 553, 1975) confused and disturbed me. Dr. Alpers stated "if the gallbladder fills on the oral cholecystogram and does not fill on the intravenous cholangiogram, that suggests that there is something wrong with the cystic duct." In cholecystography, the major difference between oral and intravenous technics is that the former allows significant enterohepatic recirculation with greater concentration of dye by the gallbladder. The filling of the gallbladder with dye during an oral cholecystogram is the sine qua non of a normal cystic duct. A block in the cystic duct is the most common cause of repeated failure to opacify the gallbladder by oral cholecystography and always indicates an abnormal gallbladder. The primary indications for intravenous cholangiography are the need for detailed examination of the common duct and the failure of the oral technic to opacify the gallbladder. In the latter circumstance intravenous cholangiography will often show an obstructed cystic duct indicating a pathologic gallbladder. I am not clear why one would do an intravenous cholangiogram in the face of