

LETTERS

Emergency contraception in the community

Madam

We read the paper by Roizen et al.¹ with interest. There is an implication in their discussion that our figures² are considerable underestimates of the true extent of repeat use of emergency contraception in the community. We would dispute this. It is surely the case that both our estimates are reasonably accurate assessments of repeat use in different populations.

Our sample was of women registered with general practitioners (GPs); 99% of the population are registered with a GP. Their sample was a subgroup (those requesting emergency contraception) of family planning clinic attenders; only 18% of women aged 16-49 years report having used a family planning clinic in the previous 5 years for any reason.³ Clearly, Roizen's sample is not representative of the general population and will differ in many respects, for example, previous sexual experience. It is known that women requesting emergency contraception are more likely to be smokers,⁴ single, nulliparous and of higher educational attainment⁵ than those who do not.

These authors suggest that some emergency contraception users may access multiple sources and that this will result in GP records underestimating the figure for repeat use. They also postulate that first-time emergency contraception users may go to a GP and then next time they require treatment they may shy away from the GP and go to a family planning clinic. The latest survey data show that the majority of women, 68%, use a GP as their source of supply of hormonal emergency contraception.³ Alternative sources used are family planning clinics (32%) and accident and emergency departments (3%).

The Office for National Statistics kindly agreed to break down their 1999 Omnibus survey data further (see Table 1). This shows remarkably little overlap in use of services – only 3% of emergency contraception users had used multiple sources. Thus, use of multiple sources seems unlikely to be a major factor in the differences between our results.

We agree that it is possible that part of the difference between our results could be due to provider attitudes and accessibility of services. This would be quite difficult to quantify. While there may be negative attitudes from some in primary health care teams, the fact remains that general practices have far longer opening hours than all but a few large central family planning clinics and provide an out-of-hours service too.

Sam Rowlands, *Reproductive & Sexual Health Services, East & North Herts NHS Trust, Health Centre, Bedford Road, Hitchin, Herts SG5 1HF, UK*

Ross Lawrenson, *Professor of Primary Health Care, University of Surrey, Guildford, UK*

References

- 1 Roizen J, Garside R, Barnett L. Repeat use of emergency contraception: how frequent is it? *J Fam Plann Reprod Health Care* 2001; **27**: 197–202.

Table 1 Where hormonal emergency contraception is obtained in Great Britain (1999^a): data in respect of women aged 16–49 years who had used the 'morning after pill' in the 2 years prior to the interview (n=199)

Where obtained	Percentage (%)
Own GP – only	60
Family planning clinic – only	29
Other GP – only	5
Accident and emergency department – only	3
Own GP and family planning clinic	2
Other combinations	1

^aF Dawe, personal communication, November 2001.

- 2 Rowlands S, Devalia H, Lawrenson R, et al. Repeated use of hormonal emergency contraception by younger women in the UK. *Br J Fam Planning* 2000; **26**: 138–143.
- 3 Dawe F, Meltzer H. *Contraception and sexual health, 1999*. London: Office for National Statistics, 2001.
- 4 Shawe J, Ineichen B, Lawrenson R. Emergency contraception: who are the users? *J Fam Plann Reprod Health Care* 2001; **27**: 209–212.
- 5 Bridgwood A. *Contraception. Living in Britain: results from the 1998 General Household Survey*. London: The Stationery Office, 2000; 164–177.

Depo Provera and bone density

Madam

Ryan et al.¹ are concerned that Depo Provera will reduce bone density and hence increase the risk of osteoporotic fracture, but their own data fail to add to an already confused area of debate.

The quality of counselling greatly affects continuation rates with Depo Provera, with discontinuation rates reported ranging from 18% to 70%.² In Ryan's study, the discontinuation rate of 69% raises questions about the quality of counselling which these women received initially. Only 48 of the original 147 patients described were still using Depo Provera after 2 years and, of these, only 32 had a bone density scan. Thus, this study presents results on a selected 22% of their original population.

The authors suggest that serum oestradiol levels are a good marker for low bone density, but provide no data on the correlation between oestradiol levels and bone density. Indeed, by selecting patients with oestradiol levels off the lower end of the scale, they are unable to test this hypothesis. Other studies suggest there is no such correlation (see review by Gbolade).³

The other striking feature of this group of women is the prevalence of other risk factors for osteoporosis. A positive family history was present in 38% of these women, 41% were smokers, and one patient was on steroids. It would appear that many of the women had more than one risk factor (e.g. both smoking and family history).

The only conclusion that can be drawn from this study is that women on Depo Provera in this general practice were highly likely to have risk factors for osteoporosis, as has also been shown in previous studies.³

Studies attempting to investigate a possible causal relationship between use of Depo Provera and low bone density should control for known risk factors for osteoporosis, and must have a comparator group drawn from the same population. There is currently no evidence to

suggest that measuring serum oestradiol has any predictive value for bone density.³

Anne Szarewski, *Clinical Consultant, Department of Mathematics, Statistics and Epidemiology, UK Cancer Research, London WC2A 3PX, UK*

Diana Mansour, *Consultant in Community Gynaecology, Head of Contraception and Sexual Health Services, Newcastle upon Tyne, UK*

Barbara A Hollingworth, *Clinical Lead in Reproductive Health, Redbridge and Havering PCTs, UK*

References

- 1 Ryan PJ, Singh SP, Guillebaud J. Depot medroxy-progesterone and bone mineral density. *J Fam Plann Reprod Health Care* 2002; **28**(1): 12–15.
- 2 Fraser I. Systemic hormonal contraception by non-oral routes. In: *Contraception: science and practice*, Filshie M, Guillebaud J (eds). London: Butterworth-Heinemann, 1989.
- 3 Gbolade BA. Depo Provera[®] and bone density. *J Fam Plann Reprod Health Care* 2002; **28**(1): 7–11.

Author's reply

Madam

The purpose of the study was to examine in clinical practice the implications of Depo Provera usage with regard to bone mass. Patients generally discontinued Depo Provera due to adverse effects despite a very positive and proactive general practitioner (GP). We were interested in long-term and not short-term users hence the small numbers. We do not imply serum oestradiol is a good marker for bone mineral density (BMD), but for various reasons as noted in the paper those with the lowest oestradiol levels would be expected to be the group where most concern exists. The paper by Gbolade et al.¹ did not show a relation between BMD and oestradiol but examined a somewhat different population with only 16/158 individuals with a serum oestradiol < 50 pmol/l. Moreover, that study appeared to ignore the observation of 13 patients with a Z score < -2.0 (12 with oestradiol < 150 pmol/l) which is a highly abnormal finding in a population of 158 normal women aged 17–52 years. We accept that many women in our study may have had risk factors for osteoporosis but this is an important and relevant clinical observation.

P J Ryan, *Consultant Physician, Department of Nuclear Medicine, Medway Hospital, Windmill Road, Gillingham, Kent ME7 5NY, UK*

Reference

- 1 Gbolade BA. Depo Provera[®] and bone density. *J Fam Plann Reprod Health Care* 2002; **28**(1): 7–11.

Letters to the Editor-in-Chief are welcome and should not normally be longer than 400 words or have more than five references. The typescript should be double line spaced. Except in exceptional circumstances, correspondence should be received within 4 weeks of publication of the article to which it refers. Correspondents should state their qualifications (maximum of two) and full address.