Issues surrounding the insertion of intrauterine contraception postpartum, when the uterus is involuting, are clearly different from first-trimester abortion but may be more similar to second-trimester abortion. However, in the absence of evidence the CEU advised that, as for postpartum insertion, following medical abortion the insertion of intrauterine contraception should be within the first 48 hours or delayed until 4 or more weeks after abortion. This advice from the CEU may be too restrictive but until more

published evidence is available an alternative recommendation cannot be made. The CEU would certainly encourage groups to publish their case series of post-abortion IUD insertions (Level III evidence) to increase the evidence base.

Susan Brechin, MRCOG, MFPP

Co-Ordinator, Clinical Effectiveness Unit, Faculty of Family Planning and Reproductive Health Care, Room 63, Aberdeen Maternity Hospital, Cornhill Road, Aberdeen AB25 2ZD, UK

JOURNAL CLUB

Implanon – the single-rod subdermal contraceptive implant. Newton J, Newton P. *J Drug Eval* 2003; **1**(6): 177–218. Parthenon Publishing Group. ISSN 1479-1137

This relatively new journal is primarily aimed at pharmaceutical physicians, but its Editor-in-Chief, Professor Ronald Mann, hopes it will also be useful to clinicians. Each issue is devoted to examining a single drug, with the intention of doing so in an independent and comprehensive manner. The Editor-in-Chief writes an 'executive summary' derived from the review.

Authors are selected on the basis of their extensive clinical experience, but are professionals who are not directly or indirectly associated with the manufacturer in a way that would prejudice independence of view and a declaration of 'conflict of interest' is required to be signed by each author.

The definition for a systematic review was given in an article in the journal in January 2004:¹ 'A critical synthesis of research evidence, which involves analysis of all available and relevant evidence in a systematic, objective and robust manner.' However, this article is not so much a systematic review as a monograph, the definition of which is 'a scholarly book, article or pamphlet on a specific and usually narrow subject'. In many ways it demonstrates the reasons why having specified guidelines is a good idea.

1. What is the research question?

This is not stated explicitly. It could be to answer the question: 'Is this contraceptive method acceptable, effective and safe?' If so, then to a large degree the question is answered, but the answers need to be extracted from a large mass of data. If the question was 'What is known so far about this method of contraception?', then again most of the answers are there, but see the caveats highlighted below.

2. Why was the review needed?

The last review of Implanon that I could find was in 1999,² so another is due. This paper is cited twice in this journal (references 29 and 56).

3. Is there a protocol outlining the review specifications? How were sources of literature identified?

The authors do not give their inclusion criteria or their searching protocol, so that it is not possible to judge for degree of bias in selection of papers or the reason for exclusion of papers. I found, on a superficial search, a list of 159 research articles on Implanon – but looking at the abstracts of some of them (it is very time consuming doing a systematic review!) several are obviously not suitable for a review article and some are repeated references.

4. Is there an assessment of the methodological quality of the articles included in the review?

The review includes a summary of the paper by Edwards and Moore² that did spell out the inclusion criteria for the studies in that paper (up to 1999). I could not find a similar list of inclusion criteria for papers published after that date, although there only appear to be eight citations after that date.

5. Was a data extraction form used? Was there any independent data extraction?

This is unknown but seems unlikely with only two named authors.

6. Were the data summarised and tabulated with synthesis of results?

Much of the data were summarised but is difficult to access in a systematic way.

7. Is the interpretation valid and the implications for practice considered?

The implications for practice are not contentious and contain no surprises.

In summary, this article may provide a useful resource for those who want information on Implanon gathered together and presented with supporting references. However, clinicians might also want to look at a health technology assessment produced for the National Health Service research and development programme in 2000³ that is easily found from the National electronic Library of Medicine (NeLM).⁴ Neither this nor a review from the Centre for Reviews and Dissemination⁵ of an economical analysis of Implanon are cited. A Cochrane Review protocol has been developed: 'Subdermal implantable contraceptives versus other forms of reversible contraceptives as effective methods of preventing pregnancy', so a systematic review will be available in due course.

References

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- 2 JE Edwards, A Moore. Implanon: a review of clinical studies. *Br J Fam Plann* 1999; **4**: 3–16.
- 3 French R, Cowan FM, Mansour DJA, et al. Implantable contraceptives (subdermal implants and hormonally impregnated systems) versus other forms of reversible contraception: two systematic reviews to assess relative effectiveness, tolerability and cost-effectiveness. *Health Technol Assess* 2000; **4**(7): i–vi, 1–107. <http://www.ncchta.org>.
- 4 <http://www.nelh.nhs.uk/>.
- 5 <http://agatha.york.ac.uk/online/nhseed/20008111.htm>.

Reviewed by **Gill Wakley, MD, MFPP**

Visiting Professor in Primary Care Development, Staffordshire University and Freelance General Practitioner and Writer, Abergavenny, UK

Clinical outcomes and costs with the levonorgestrel-releasing intrauterine system or hysterectomy for treatment of menorrhagia. randomized trial 5-year follow-up. Hurskainen R, Teperi J, Rissanen P, et al. *JAMA* 2004; **291**: 1456–1463

This study is from all five university hospitals of Finland. In some countries the levonorgestrel-releasing intrauterine system (LNG-IUS) is licensed and/or being used to treat menorrhagia. The commonest indication for hysterectomy is menorrhagia, so it is important to consider whether possible alternatives to surgery are effective and cost-effective.

This study gives the 5-year results of a previously published 1-year study.¹ Of 236 women referred to the hospitals with menorrhagia, 119 were randomised for LNG-IUS treatment and 117 for hysterectomy. Only 12 women failed to complete the 5-year follow-up. The Health-Related Quality of Life (HRQL) was measured using the five-dimensional EuroQol system and the RAND 36-item system. The Spielberger Anxiety Inventory, the Beck Depression Inventory and the McCoy Sex Scale were all assessed. Overall satisfaction was assessed by a five-level question.

Cost analysis was calculated taking account of medical treatment, sick leave, and so on based

References

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- 3 World Health Organization (WHO). *Medical Eligibility Criteria for Contraceptive Use*. Geneva, Switzerland: WHO, 2000.
- 4 Heartwell S, Schlesselman S. Risk of uterine perforation among users of intrauterine devices. *Obstet Gynecol* 1993; **61**: 135.

on Finnish costs. Results at 5 years showed that the two groups did not differ substantially in terms of the HRQL; 94% of the LNG-IUS group and 93% of the hysterectomy group were satisfied or very satisfied. The haemoglobin and serum ferritin levels were significantly higher at 5 years than at base line, with no substantial difference between the groups. However, 50 (42%) women in the group allocated to the LNG-IUS eventually underwent hysterectomy. Of the 57 women with an LNG-IUS in situ at 5 years, 75% reported amenorrhoea or oligomenorrhoea and 19% reported irregular bleeding. In the group allocated to hysterectomy, 109/117 had hysterectomy. Complications included three bladder perforations and one bowel perforation.

The average total cost was US\$2817 in the LNG-IUS group and US\$4660 in the hysterectomy group, i.e. the LNG-IUS costs were 40% less. When hysterectomy costs are placed at 20% less or placed higher than USA costs, the LNG-IUS costs were still considerably less.

In Finland the use of hysterectomy has been falling while the use of the LNG-IUS has been increasing. The authors conclude the LNG-IUS may improve HRQL at relatively low cost despite the need for some women to eventually require hysterectomy.

The study certainly confirms the LNG-IUS as an effective treatment for menorrhagia. This being the case it is puzzling why *Clinical Evidence*² describes it as being of 'unknown effectiveness'. All the more surprising when their own supporting literature review amply confirms its effectiveness! Probably their failure to endorse the LNG-IUS is because there has never been a randomised controlled trial of the LNG-IUS versus placebo, which of course can never occur.

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- 2 Godlee F (exec. ed.). *Clinical Evidence Concise*. 9th Issue. *Women's Health Section*. London, UK: BMJ Publishing Group, June 2003; 393. <http://www.nelh.nhs.uk/clinicalevidence>.

Reviewed by **Michael Cox, FRCOG, MFPP**

Consultant Obstetrician and Gynaecologist (Retired), Nuneaton, UK

Preconception care practice and beliefs of primary care workers. Heyes T, Long S, Mathers N. *Fam Pract* 2004; **21**: 22–27

The authors explored the views of health practitioners working in primary care in Barnsley Health Authority (in the north of England) about preconception care. They obtained a response rate of 61% from general practitioners (GPs), practice nurses, health visitors and midwives in July 2000. Most of those who replied were providing preconception care on an opportunistic basis and infrequently. Few general practices had any written policy. The respondents agreed that advice on smoking, drug use, folic acid, genetic counselling, chronic disease, alcohol and screening was important. Screening advice included rubella, genital infections, hepatitis, human immunodeficiency virus and cervical screening. They felt that advice about diet, exercise, supplements, food safety, occupational hazards and state benefits were less important. Giving preconception advice was not a high

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priority, although the respondents felt that it was effective and important (but gave no evidence for this). The respondents felt that general practice was the best place to give this advice and that they had the necessary skills, although few had received any training. Barriers to providing the advice were, as usual, lack of time and resources as well as lack of contact with women planning to conceive. The authors suggest that research is needed into ways that preconception care can be provided. There seemed little appreciation of alternative views that this task might be more suited to a public education campaign that might also reach those women who do not attend general practice.

Reviewed by **Gill Wakley**, MD, MFPF
Visiting Professor in Primary Care Development,
Staffordshire University and Freelance General
Practitioner and Writer, Abergavenny, UK

Serum medroxyprogesterone acetate levels in new and repeat users of depot medroxyprogesterone acetate at the end of dosing interval. Smit J, Botha J, McFadyen L, et al. *Contraception* 2004; **69**: 3–7

This study was undertaken as there was no research evidence of the serum levels of serum medroxyprogesterone acetate (MPA) in the African population. A total of 97 women were recruited and 94 returned for a follow-up visit. Some 24% of the population had used the method for three or fewer injections and the remainder had been using depot medroxyprogesterone acetate (DMPA) for more than a year. The serum MPA was measured in a sample of blood taken before the next injection at the follow-up visit. The results showed no consistent level of MPA and no statistical

difference when allowing for body mass index (BMI) and length of time using the method. There was only one woman recorded as being below the level of 0.1 mg/ml of MPA (the level at which ovulation is inhibited).

This study confirms that the levels of MPA at the time of the next injection are not related to BMI or length of time used and levels are very variable in any population. Almost all women will have levels of MPA that will still suppress ovulation. We should be wary of the occasional woman whose levels are low enough not to inhibit ovulation if she is late with an injection.

Reviewed by **Judy Murty**, DRCOG, MFPF
SCMO, Contraceptive and Sexual Health
Services, Leeds, UK

NEWS ROUNDUP

Young people ignorant about STIs

The American Social Health Association (ASHA) questioned more than 1000 people aged between 18 and 35 years of age. Although 84% said that they took precautions to prevent sexually transmitted infections (STIs), the follow-up questions showed that this was not true. Although 93% thought that their partner did not have a STI, one in three had never discussed STIs with their partners – so how did they know? Of those questioned, 68% were not worried that they might contract a STI: the well-known 'It won't happen to me' scenario. Nearly half used no protection during vaginal intercourse, 66% used no protection during anal intercourse and only 9% used any protection for oral sex. The survey was mainly designed to identify the level of knowledge about hepatitis A and B, both of which can be transmitted sexually. The authors of the report were concerned by the results that more than half of those surveyed didn't know that hepatitis A and B can be sexually transmitted, the respondents were unaware that vaccines were available, and did not know if they had been immunised against either of the infections. Although hepatitis B is much more infectious than human immunodeficiency virus, young people seemed to know less about it. Further information is available at: <http://www.ashastd.org/press/040504viral/hepatitis.html>.

Department of misinformation

A press release from the 'Family Research Council' quotes Kathleen M Gallagher, director of pro-life activities for the New York State Catholic Conference, commenting on a report advocating over-the-counter emergency contraception (EC). Gallagher said "Havesi's report promotes dangerous public policy that could result in the repeated distribution of mega doses of hormones to girls and women without physician oversight or parental supervision for children. Even the FDA has stated that the effect of repeated use of these pills is unknown. These chemicals sometimes cause abortions by

destroying growing embryos and, through over-the-counter availability, women would be denied even this basic knowledge. Women deserve better." Perhaps this spokeswoman should gain some basic knowledge about the dose of progestogen-only EC and its actions? Readers of this Journal are often unaware of the dangerous myths promulgated by people with a fixed-belief system and should take every opportunity to dispel the misinformation. The Family Research Council has as its motto 'Defending Family, Faith and Freedom' and its website contains some gems of biased reporting. Further information is available at: <http://www.frc.org>.

Good news about sex and age

A Swedish study reported on several news gathering sites reveals that nearly all 70-year-olds would be sexually active if they could. Nils Beckham from Gothenburg University polled 1658 70-year-olds. In 1971, only 0.8% of 70-year-old women said they were sexually active, now the proportion is 13%. Many more women of this age are living with a partner or are married as compared with 30 years ago. The proportion of men claiming to be sexually active has risen from 50% in 1971 to 69% today. More men tended to have partners who were younger than themselves. Unfortunately, the source for this information is in Swedish, but searching for this information on Google provoked much hilarity. (NB. The author thanks Susan Quilliam for drawing this press release to her attention.)

Topiramate and COC

The levels of interactions between topiramate and a combined oral contraceptive (COC) (containing 35 µg ethinylestradiol and norethindrone) were compared with those between carbamazepine and the COC in a recent publication.¹ Hormone levels were measured over two cycles in groups of women on different doses of topiramate and in one group whose basal metabolic indexes were between 30 and 35. Small, non-significant changes occurred in the groups of women taking any of the doses of topiramate compared with a marked difference in the group taking carbamazepine. The levels of oestrogen in the latter group were significantly lowered. The

authors concluded that topiramate, at daily doses of 50–200 mg, does not interact with a COC containing norethindrone and ethinylestradiol and it seems plausible to generalise this finding to other COCs. Women taking topiramate can be reassured that no extra contraceptive precautions or increased dose of COC is required.

Reference

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Condoms and HPV infection

We know that some infections with human papilloma virus (HPV) contribute to the development of cervical cancer. A commentary from the American journal reporting on control measures for cancer¹ discusses what advice we should be giving to patients about the role of condoms. The commentary reviews a couple of studies from The Netherlands that suggested that condom use might be associated with the regression of cervical intra-epithelial neoplasia and in men with HPV-related penile lesions. The studies concluded that the results showed that the lesions regressed in the group that used condoms compared with the carefully matched group not using condoms. HPV was more quickly cleared in the condoms users also. The researchers suggest we should be advocating condom use as a means of promoting HPV clearance and regression of lesions. However, the commentary points out some caveats. The studies showed little difference in those people who had lesions for more than 6 months. Most HPV infections are transient and are likely to clear anyway. Many of the infections that we detect in clinical practice will have been present for longer than 6 months. However, using a condom is likely to prevent re-infection with HPV, infection with another type of HPV or other infections. As usual, further research is needed!

Reference

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Reviewed by **Gill Wakley**, MD, MFPF
Visiting Professor in Primary Care Development,
Staffordshire University and Freelance General
Practitioner and Writer, Abergavenny, UK

BOOK REVIEWS

Obstetrics and Gynaecology: An Illustrated Colour Text. J Pitkin, A Peattie and B Magowan. London, UK: Churchill Livingstone (Elsevier at www.elsevier.com), 2003. ISBN: 0 443 05035 X. Price: £19.99. Pages: 161 (paperback)

This slim but concise book is a highly readable introduction to obstetrics and gynaecology. Most topics are covered on one double-page spread,

with good use of illustrations and text boxes. The text is generally well written and also demonstrates a positive attitude to caring for the whole patient.

The authors are all hospital-based consultants in obstetrics and gynaecology. Hospital-based aspects of the speciality are accurate and up to date, however the contraception section is disappointing. The authors think that progestogen implants such as Implanon® are biodegradable and do not require removal. The progestogen-only vaginal Fem-ring® is described as if it is already in clinical use. It is hard to resist the notion that

hospital specialists know less about contraception than they think.

This book is written from a UK context, making the book pleasantly readable to a UK audience. It would provide a good introduction to the specialty for medical students and also an excellent concise revision source for doctors preparing for DRCOG and MFPF examinations.

Reviewed by **Kate Weaver**, MB ChB, MFPF
Staff Grade Doctor in Reproductive Health Care,
Edinburgh, UK