Abortion law

I read the commentary[1] on 'Abortion law: campaign groups and the quest for change' in the October 2006 issue of the Journal with interest. In general, it provides a very balanced overview of the different groups seeking change in UK abortion legislation, summarising the concerns of both pro-life and pro-choice organisations.

However, in his discussion and conclusions, Dr Vincent Argent ceases to be impartial and reveals his own prejudices, consistent with his position as Medical Director of bpas. He asserts that anti-abortion campaigners are seeking to "whittle away" at the legal provision of abortion until such time as they can prevent abortion taking place altogether. This is patently not true. At least two of the pro-life organisations cited are aiming to reform abortion legislation and to see it enforced properly, but do not seek to ban it altogether.

He then describes the sentiment that "the smaller and less well developed the fetus is, the less they feel uncomfortable about the idea of abortion" as a common-sense pragmatic view. He is thus implicitly labelling any who do not hold to this sentiment as lacking common sense.

Finally, in his conclusion, Dr Argent suggests that "the majority of women in the UK agree with those groups calling for change in the law to allow easier and earlier access and women's choice on abortion". On what evidence does he base this statement? The only evidence he alludes to is in the sentence "Other polls generally show support for earlier abortion on request and improved access".

He does mention a recent MORI poll, which claimed that 47% of women believe the legal time limit for abortion should be reduced from 24 weeks. But he makes no specific reference to the "other polls", which he claims show that the majority of women in the UK would like easier access to abortion.

Having read earlier in the commentary about the views of five large organisations that are pro-life, it appears that many women would support either reduced access to abortion or stricter enforcement of the current abortion law as originally intended. I therefore find it difficult to believe Dr Argent's assertions without proper evidence to back them up.

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Reference
1 Argent V. Abortion law: campaign groups and the quest for change. *J Fam Plann Reprod Health Care* 2006: **32**: 215–217.

Reply

Shortage of space in a journal always constrains the amount of material in any commentary. References to support the view that "other polls generally show support for earlier abortion on request and improved access"[1] have been widely available. They include one on 'Women's perceptions of abortion law and practice in Britain'[2] carried out by BMRB Social Research for Marie Stopes International. This showed that 88% of women believed that decisions about abortion should rest with the woman concerned and that 67% believed that abortion should be free on the National Health Service.

The State of the Nation poll by the Joseph Rowntree Reform Trust[3] found that 76% of the UK population were pro-choice. The Royal College of Obstetricians and Gynaecologists reported that one in three women have an abortion in their lifetime and that almost 90% of abortions take place in the first 12 weeks of pregnancy.[4] These large numbers provide a practical demonstration of the wishes of women to have access to early abortion.

The argument about abortion on request is also widely debated. A woman has no right to terminate an unwanted pregnancy and must depend entirely on the opinions of two medical practitioners. This may well be seen by the public as out of step with the increasing priority given to a patient's right to make their own decisions about their medical treatment in other fields of medicine.

It is perhaps more important to try and reduce the need for abortion by focusing on the maintenance and improvement to the provision for contraception, particularly of long-acting methods.[5] Health professionals, unfortunately, have little impact on the social changes required to increase the awareness of the risk of pregnancy from any act of sexual intercourse.

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How can we reduce unintended pregnancies?

Unintended and unwanted pregnancy rates continue to rise in England and Wales. These rates largely translate into termination of pregnancies, the bulk of which occur in teenagers and in younger women aged 25 years or less.[1] These high rates occur against the background of free contraceptive services. It would appear then that apathy to the use of contraception by women is an important contributory factor. It is possible also that the wrong choices regarding contraception are being made by women and their doctors. There is evidence that about 50% of all pregnancies are unplanned, and in early or late reproductive life such pregnancy is commonly unwanted and is likely to be terminated.[2]

This makes the proper use of effective contraception the most important intervention in the prevention of unintended pregnancies and hence unwanted pregnancies. There is evidence that most women seeking termination of pregnancy are not using contraception at all, using condoms which depend largely on proper user application for effectiveness, or using ineffective contraception by haphazardly taking the oral contraceptive pill.[3] Such women also recognise that the contraceptive of choice for them is one that they do not have to remember to take.[4] Long-acting reversible contraceptives (LARCs) would be the contraceptives of choice for these women. These are the depot medroxyprogesterone acetate injection (Depo-Provera®), the progestogen subdermal implant (Implanon®), progestogen intrauterine system (Mirena®) and copper intrauterine devices.

The guidelines by the National Institute for Health and Clinical Excellence (NICE)[5] endorsing LARCs as the contraceptive methods of choice is to be commended and it is hoped that these can make an impact in reducing unintended or unplanned pregnancy rates and hence unwanted pregnancies and termination of pregnancy rates. For this reduction in unwanted pregnancies to occur, the guideline needs to be embraced wholeheartedly by all practitioners especially in primary care and family planning clinics, where the bulk of contraceptive care in the UK is provided. The guideline makes the case eloquently in terms of efficacy and cost-effectiveness. For the younger woman or teenager the case for using a LARC cannot be overemphasised as sexual intercourse commonly is unplanned and may also occur under the influence of alcohol. This group of women also lead busy and some times chaotic lives – a scenario lacking in the orderliness, discipline and the forward planning necessary for the successful use of a daily applied method of contraception such as the pill or condoms.

All family planning clinics and general practice surgeries should, as a matter of urgency, become conversant with the insertion or administration techniques for these LARCs. The oral contraceptive pill should be prescribed only where short-term contraception is required (e.g. where a pregnancy is desired within 3 months or less). Condom use needs to be promoted, mainly as protection against sexually transmitted infections, and LARC as protection against pregnancy.

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5 *Long-acting Reversible Contraception.* Guideline Commissioned by the National Institute for Health and Clinical Excellence (NICE). London, UK: RCOG Press, 2005. http://www.nice.org.uk/pdf/CGO30fullguideline.pdf [Accessed 16 November 2006].

Increase in IUD expulsions

I read with interest the letter from Frank Hawkins and Nanas Callander in the October 2006 issue of the Journal.[1]

A few years back I published a similar letter in the Journal,[2] which was followed by a lot of correspondence over a period of a year and the journal editor had to stop further correspondence with the promise of publishing a special review article on the topic.

Those days it was Gyne-T Safe® intrauterine device (IUD). I had problems like other displacement with the thread too long or expulsion. After much trial and error with the plastic model I felt there was something wrong with the design and I approached the manufacturer, however they did not even have the courtesy to acknowledge my letter. After my letter was published in the Journal[2] the company sent a representative to discuss the issue.

What I suggested was that the tube holding the IUD was rather snug fitting and also that the introducer rod was short of the outer opening. As a result the IUD didn't emerge completely from the tube and during removal of the tube the IUD was pulled down with it. I therefore used to line up the rod a few millimetres just above the top end of the tube and cut the tube with scissors, which ends at the lower end of the rod, like a stopper above ring. After that it was very easy to load the IUD, introduce it and pull the tube up to

the end of the stopper ring and since then I never failed. Many colleagues have tried this method and they have had success with it also.

I had correspondence from the French company that unless the article were to be endorsed by a professor or senior consultant/colleague in family planning then they were not prepared to change the design. The Ortho Gynae T 380® was discontinued, however it has been adopted for use by other manufacturers with only minor changes, and I am afraid the inherent problem is still present. One has tried to make loading easier but still the problem doesn't disappear completely.

My proposal was very simple: no matter how you load the introducer rod in the tube it should come out outside the top opening and then one can be absolutely sure that the IUD is released totally and completely and that there is no chance of the IUD being pulled down.

For those colleagues who would like to try my technique they should do the following. Put the IUD on sterile paper. Pull the IUD out further up so that one does not cut the thread. Line the rod against the tube with the rod just a few millimetres (say 4–5 mm) higher than the opening and then the lower end of the tube should be cut, which should rest at the end of the rod where there is a ring. Subsequent fitting should now be easier.

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1 Hawkins F, Callander F. Increase in IUD expulsions (Letter). *J Fam Plann Reprod Health Care* 2006; **32**: 267.
2 Yadava RP. Self removal of Mirena IUS (Letter). *Br J Fam Plann* 1997; **22**: 59.

Increase in IUD expulsions

I write as the UK distributor for the TT 380 Slimline® intrauterine device (IUD), following the publication of the letter from Drs Hawkins and Callander in the October 2006 issue of the Journal concerning IUD expulsions.[1]

Neither Durbin PLC, nor the French manufacturer (7-MED Industrie), can explain what has happened, although the clinical skills of the two doctors are beyond reproach. Since 2002 approximately 205 000 TT 380 Slimline devices have been fitted in France alone, with only three reported expulsions.

There is a European Standard for the 'resilience' of the horizontal arms which the TT 380 Slimline meets, and the manufacturer does not accept that the way the arms regain their shape after compression is connected to the reported expulsions.

I would refer the Journal's readers to the poster presentation by Dr Paul O'Brien (Westminster PCT, London, UK) at the 8th Congress of the European Society of Contraception held in Edinburgh, UK in June 2004. (NB. Copies of the poster are available from me on request.) This poster reviewed published studies on the T380 'A' version (where the copper sleeves on the horizontal arms stand proud of the plastic) and the T380 'Slimline' version (where the copper on the arms is flush with the plastic and closer to the ends), which may cast some light on the topic.

Dr O'Brien's review revealed an increase in expulsions in the first year with the 'Slimline' version compared to the 'A' version. By Years 4 and 5 the expulsion rates with both types were similar.

The T-Safe 380 A changed to the 'Slimline' format in June 2005. The results of Dr Hawkins and Callandar refer to T-Safe usage up to Autumn 2005. Allowing for the stock holding in the distribution chain, it is probable that most of the T-Safe devices fitted in the period referred to were of the original 'A' style. (NB. It is interesting to note that although all the T-Safe devices now available are of the 'Slimline' type, the product is still described as '380 A' on its packaging!)

Notwithstanding all of the above remarks, the manufacturer of the TT 380 Slimline device, in view of the volume now used in the UK, have proposed some design changes purely for the UK market. These changes, which will be on stock produced from January 2007, will result in an increase in the resistance to expulsion.

Any readers requiring further information, evaluation samples, and so on, are invited to contact me directly.

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1 Hawkins F, Callander F. Increase in IUD expulsions (Letter). *J Fam Plann Reprod Health Care* 2006; **32**: 267.

Ancient condoms

Further to the article in the October 2006 issue of the Journal on the history of condoms,[1] readers may be interested to know that amongst the finds in Tutankhamen's tomb was a linen condom with long strings to attach. The condom is now on show in the Cairo Museum alongside the more famous artefacts, which goes to show that one can't be too careful – even in the afterlife!

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Reference
1 Edouard L. In condoms we trust: to each, one's own. *J Fam Plann Reprod Health Care* 2006; **32**: 262–264.

NEWS ROUNDUP

EURAS Study results

Final results of the European Active Surveillance (EURAS) Study were presented at the XVIII FIGO World Congress of Obstetrics and Gynaecology in Kuala Lumpur, Malaysia on 9 November 2006. This post-marketing surveillance cohort study took place between 2000 and 2006, with 58 674 participants followed up for 142 475 woman-years. The aim of the study was to monitor cardiovascular outcomes in combined oral contraceptive (COC) users, specifically comparing those on Yasmin® with other COC users. The scale of the study, amount of detailed information collected about each woman (with regard to relevant cardiovascular risk factors) and the fact that only 2.39% of women were lost to follow-up make this a unique and useful investigation.

As has been noted in previous studies of cardiovascular risks, women using the newest preparation (in this case Yasmin) were at slightly higher risk at entry (e.g. were more likely to be obese). Interim results of this study had already shown higher than expected absolute risks of venous thromboembolism (VTE) in all groups, and the final results showed a risk for non-pregnant, non-COC users of 44 per 100 000 woman-years. All COC users, regardless of preparation, had a similar, elevated risk of VTE, at approximately 90 per 100 000 woman-years. The risk was increased to 230 per 100 000 in women with a body mass index (BMI) over 30, which was a five-fold increase compared to women whose BMI was 20–24 and a three-fold increase compared to those whose BMI was 25–29. Increasing age was also a significant risk factor.

No increase was seen in risks of arterial disease for any preparation, compared to non-users. The study results are to be published in the journal, *Contraception*, early in 2007.

Reported by **Anne Szarewski**, PhD, FFFP
Editor-in-Chief, Journal of Family Planning and Reproductive Health Care

Risk of VTE with oral contraceptives

A free communication presented at the XVIII FIGO World Congress of Obstetrics and Gynaecology in Kuala Lumpur, Malaysia investigated whether gestodene-containing oral contraceptive (OC) pills carried a higher risk of venous thromboembolism (VTE) compared to levonorgestrel-containing OCs. A population-based case-control study was undertaken in 2005 amongst Austrian women aged between 15 and 49 years. Interim results were presented involving 408 cases and 1339 controls. The odds ratio for developing a VTE with an OC versus non-use was 2.8 (95% CI 2.1–3.6) for all OCs, 2.7 (95% CI 1.9–3.8) for gestodene-containing OCs and 2.9 (95% CI 1.5–5.8) for levonorgestrel-containing OCs. A head-to-head comparison comparing gestodene-containing versus levonorgestrel-containing OCs showed an odds ratio of 1.2 (95% CI 0.6–2.7).

This study confirmed an increased risk of VTE associated with the use of any combined OC pill, with a similar odds ratio to that found in previous studies. However, in 2005 there was no significant difference in VTE risk in this population of women taking a gestodene-containing pill compared to a levonorgestrel-containing pill. It is important to note that this study was designed to reduce potential confounders and biases by using controls with the same year of birth from this same region of Austria as the identified cases. The cases included those who had VTEs diagnosed and treated in an outpatient setting as well as inpatients.

The authors conclude that their contemporary study results differ from those found in the 1990s because user populations of second- and third-generation OC pills have changed.

Reference
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