# LETTERS

## GP use of anti-D

Madam,

I read with interest the letter on GP use of anti-D recently published in the *British Journal of Family Planning*.[1] The Joint Working Group of the British Blood Transfusion Society and the Royal College of Obstetricians and Gynaecologists have recently published recommendations for the use of anti-D immunoglobulin for rhesus prophylaxis.[2] Evidence suggests that the risk of immunisation by spontaneous miscarriage before 12 weeks gestation is negligible when there has been no instrumentation of the uterus to evacuate products of conception. The Joint Working Group recommend that anti-D is therefore not required when a women suffers a miscarriage prior to 12 weeks gestation and no instrumentation of the uterus is carried out. Similarly, as there is scant evidence that women are sensitised after uterine bleeding in the first 12 weeks of pregnancy where the fetus is viable and the pregnancy continues, the Joint Working Group recommend that the routine administration of anti-D is not required. Only when bleeding is heavy, or repeated, or when there is associated abdominal pain – particularly when these events occur as gestation approaches 12 weeks – is the administration of anti-D suggested.

As discussed in the letter, early pregnancy bleeding is being increasingly managed in primary care. However, it is likely that most of these women will be less than 12 weeks gestation, will not have had any instrumentation of their uterus and will not have suffered heavy, repeated or painful bleeding, as these problems would usually lead to hospital referral.

The study outlined in Dr's Goulding and Hamilton's letter examined the care of women prior to the publication of the Joint Working Groups recommendations. As the gestational ages at which the miscarriages referred to are not given, it is difficult to conclude that these ladies, in the light of current recommendations, received inadequate care.

It is clear, therefore, that GPs are unlikely to solely manage many patients with early pregnancy bleeding who require anti-D immunoglobulin. As Goulding and Hamilton suggest, protocols are essential to ensure anti-D is administered to women who require it. Equally important is that such protocols incorporate the recent guidance by the Joint Working Group's recommendations to ensure that only women who truly require anti-D are receiving it when needed.

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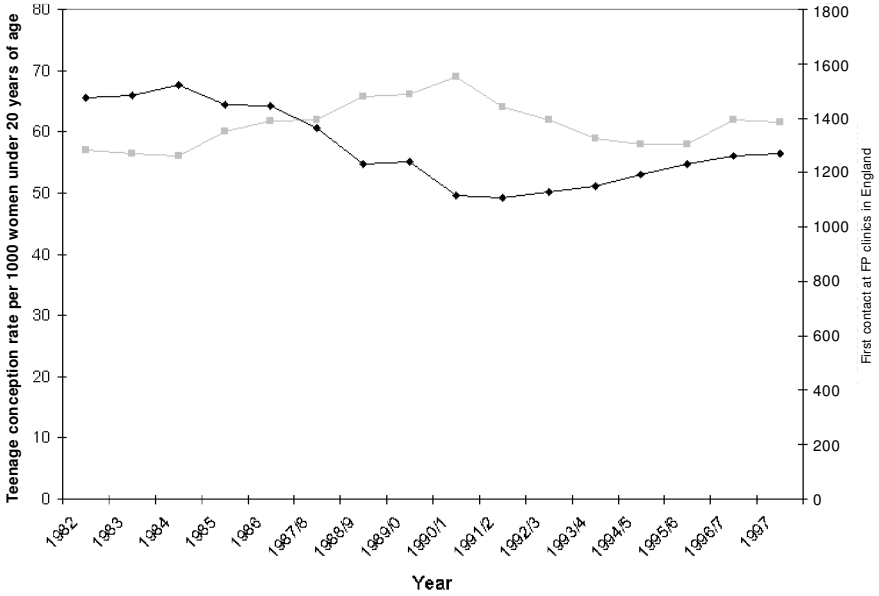
*References*
1 Goulding C, Hamilton W. GP use of anti-D. *The British Journal of Family Planning* 2000; **26(2):** 116.
2 Joint Working Group of the British Blood Transfusion Society and the RCOG. Recommendations for the use of anti-D immunoglobulin for Rh prophylaxis. *Transfusion Medicine* 1999; **9**: 93-97.

## How effective are family planning clinics?

Madam,

Careful analysis by economists[1] has demonstrated the cost effectiveness of family planning (FP) services. It is estimated that the 0.5% of the total NHS expenditure allocated to FP avoids 3.8 million unplanned pregnancies per year, which saves 2.5 billion pounds per annum to the NHS alone. Put simply, that for every £1 spent on FP, the NHS saves £11. But how effective are clinics in terms of clinical outcomes?

**Figure 1** *How effective are family planning clinics? Teenage pregnancy rate and FP clinic usage*




The trend in teenage births and abortions may be plotted over the same time scale as the cuts and expansion of FP clinics (Figure 1). This does not prove or cause a relationship (i.e. that cuts *cause* unwanted pregnancies), but there appears to be an association.

There was a modest expansion of FP services and attendance rates from when the NHS took over from the FPA in the mid 1970s to the early 1980s. This coincided with a gradual fall in teenage pregnancy rates. Financial reductions during the mid and late 1980s saw the closure of many clinics and a fall in attendancies. During this period teenage pregnancies rose to their highest level. From the early 1990s extra investments in FP clinics came from HIV and Health of the Nations allocations, and some priority was given to the prevention of teenage pregnancies by Health Authorities. The resulting expansion in clinics coincided with an overall trend to lower teenage pregnancies.

I am interested in readers' interpretations about the importance to Primary Care Groups and future Primary Care Trusts of investment in clinical services to compliment GP contraceptive provision.

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*Reference*
1 McGuire A, Hughes D. The economics of family planning services. A report prepared for the Contraceptive Alliance. London: Family Planning Association 1996.

## Personal hormone monitoring for contraception

Madam,

We wish to respond to Trussell's criticism[1] of our estimated method failure rate of 6.2% for Persona[2] as too low. He states that we used a variant of a technique 'known to produce a misleadingly low estimate of the risk of pregnancy when a contraceptive is used correctly and consistently according to instructions'. Correct and consistent use of a contraceptive is termed 'perfect use' by Trussell. The pregnancy rate calculated from cycles with only perfect use is claimed to measure the 'inherent' failure rate of a contraceptive method. It is intended to inform the user of the risk of pregnancy if the method is used correctly and consistently for 1 year.

First, we cannot agree that the perfect use rate measures the 'inherent' failure rate of a contraceptive. The concept of an inherent failure rate is ill defined. It may depend on the mode of action of the method, particularly of a behavioural method, such as Persona, which provides no physical or physiological barrier to conception other than the avoidance of intercourse at specified times.

Second, perfect use analysis assumes that the underlying method failure rate during perfect and imperfect use is the same. However, for Persona this assumption is wrong. Compliance with sexual abstinence rules is easier in cycles with few red days and many green days. Hence perfect use is more likely. The effect may be clearly seen in Figure 1, which is a graph of the probability of perfect use against the number of red days. No method of contraception is 100% effective. The 94% efficacy claim for Persona represents a low risk of pregnancy associated with intercourse on green days, days that are termed 'safe'. Within this context, a green day in a cycle with few red days is on average potentially less 'safe' than a green day in a cycle with many red days. Therefore, when considering the data from the trial, a green day in a perfect use cycle is potentially less 'safe' than a green day in an imperfect use cycle. Since intercourse on a green day in a perfect use cycle is less 'safe' than in an imperfect use cycle, the perfect use method failure rate will tend to overestimate the method failure rate expected in a 'real life' situation.

As Trussell states, a perfect use analysis is a 'convention' excluding all cycles of potential exposure to method failure in which there is at least one infringement of the contraceptive rules. Our third objection is that such an analysis ignores a large proportion of the data. For

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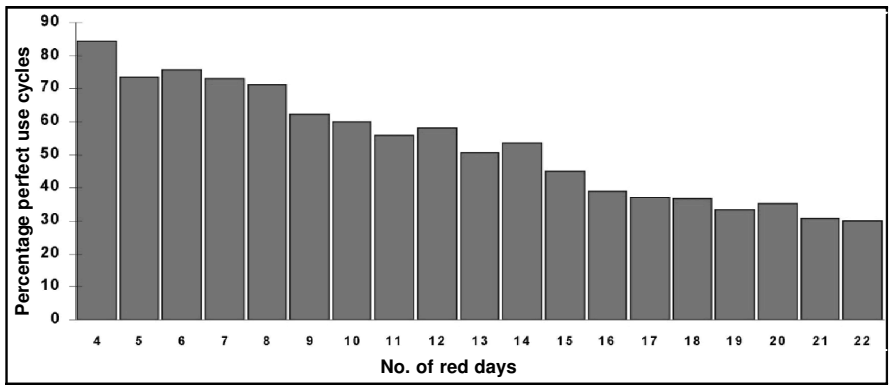
**Figure 1** *Personal hormone monitoring for contraception*




example, in the Bonnar et al study,[2] just over half of cycles had perfect use.

The two estimates of the method failure rate (our approach and perfect use) are, in fact, the answers to different questions:

1. What is the pregnancy rate due to intercourse on green day(s) in any cycle?
2. What is the pregnancy rate due to intercourse on green day(s) in cycles with intercourse only on green days (i.e. perfect use)?

We preferred the former, i.e. the rate of 6.2% for Persona, because it reflects the experience of 95% of study cycles rather than the 57% we could describe as perfect use. We were able to employ the uniquely detailed data from the Persona study to estimate the rate.

Trussell criticises us for including cycles with no risk of a method pregnancy in the denominator of our method failure rate calculation. We thank Trussell for clarifying this point. The task he has identified is to determine which imperfect use, non-pregnancy cycles would have been classified as method failures if a pregnancy had occurred. Given the hypothetical nature of the question, to make such a classification convincingly is extremely difficult, if not impossible. The denominator we actually used includes cycles classifiable as potential method failures since there was at least one green day with an act of intercourse.

We do not accept that our approach is based on flawed logic. Both perfect use and our analysis can present difficulties in arriving at rigorous estimates of method failure, and further research is needed to refine the definition of inherent contraceptive efficacy and of the true method and user failure rates for different methods of contraception. Where possible, it is important to try to achieve comparability between methods, to provide accurate and meaningful estimates of such rates in real studies, and to improve the design of future trials of contraceptive efficacy. By emphasising the need to study the user's behaviour as Persona does, the detailed estimation of actual exposure to pregnancy, made possible by identifying potentially fertile days, is an important advance.

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*References*
1 Trussell J. Contraceptive efficacy of the personal hormone monitoring system Persona. *The British Journal of Family Planning* 1999; **25 (2)**: 34-35
2 Bonnar J, Flynn A, Freundl G, et al. Personal hormone monitoring for contraception. *The British Journal of Family Planning* 1999; **24 (4)**: 128-134.

## Perforation with GyneFix IUD

Madam,

I think the 'Important Notice' about perforations with GyneFix published by Dr Wildemeersch[1] is timely.

Personally, I know of two perforations that have occurred with this device. Therefore, I support Wildemeersch's list of recommendations for reducing the risk.

There have been other reports of perforation with GyneFix.[2] What Dr Wildermeersch does not comment on is the perforation rate in Belgium when the device was launched.[3] In the first 5 000 insertions, there were seven perforations documented.

The problem may be due to the inexperience of practitioners. However, there needs to be continuing surveillance of perforations to make sure that this device is safe when used appropriately.

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*References*
1 Wildemeersch D. Important Notice. *Br J Fam Plann* 2000; **26**: 88
2 Vekemans M, Verougstraete A. Late uterine perforation with an anchored IUD. *Contraception* 1999; **60**: 54-56.
3 Piette P. Drug surveillance report. Drogenbos, Belgium: Laboratoires Piette International, 1997.

## Quality of information on the Internet

Madam,

We are writing to point out the errors in the study 'Quality of information on emergency contraception on the Internet' by Latthe, Latthe and Charlton in the January 2000 issue.[1]

Our website, www.opr.princeton.edu/ec (now accessible through not-2-late.com), is listed twice, as two separate websites (sites 8 opr.princeton.edu/ec/ec.html and 12 opr.princeton.edu/ec/hotline.html) and with different ratings in 12 of the 26 categories. In addition, we have always provided dose information for both combination and progestogen-only pills; to be given a negative rating in this category only shows us how little attention the reviewers paid to content. Finally, while the authors define currency as 'keeping up to date with the present state of medical knowledge' their sole criterion for a positive rating is the date that information was posted by webmasters, not at all an indication of current medical and professional opinion.

While we applaud the concept of monitoring the quality of medical information on the Internet, it is evident, both from the methodology and the results, that the authors were not sufficiently thorough in this undertaking.

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**Tara Shochet**
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*Reference*
1. Latthe, M, Latthe PM, Charlton R. Quality of information on emergency contraception on the Internet. *Br J Fam Plann* 2000: **26(1)**: 39–43.

## Authors' response

Madam,

We read with interest the comments of Trussell and Shochet. It should be stated that at the time of the study Princeton University had two sites coming up on the search engines, which appeared separate from each other. They were assessed from what we were able to access on the day we conducted our search. However, some pages within sites were not accessible and hence the different ratings.

These ratings were dependent on the date of posting of information on the web sites. Our criteria were the same as the quality assessment tool used in related studies.[1] Our scientific method therefore remains valid, and has also emphasised the need for web sites to be regularly updated and assessed externally to exclude user problems.

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*Reference*
1. Kim et al. Published criteria for evaluating health related web sites: review. *Br Med J* 1999; **318**: 647–649.

Letters to the editor are welcome and should not normally be longer than 400 words or have more than five references and type should be double spaced. Except in exceptional circumstances, correspondence should be received within 4 weeks of despatch of the most recent Journal. Correspondents should state their qualifications and address. Letters should be supported by a statement on competing interests.

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