

LETTERS

Nova T® 380 and levonorgestrel IUS studies

Madam,  
The UK Family Planning and Reproductive Health Care Network have recently completed 5 year studies on these two devices, and following Dr Bacon's letter<sup>1</sup> we thought it may be useful to give the 24 month results of these studies (Table 1), which have now been published elsewhere.<sup>2,3</sup>

Table 1 Cumulative life-table gross closure rates at 24 months

	Nova T 380	Levonorgestrel IUS
N	572	692
Pregnancy	1.9	1.1
Expulsions	9.1	5.3
Removal for bleeding problems	17.8	11.9
Pelvic inflammatory disease	1.0	1.1
Removal to plan pregnancy	8.3	8.2

In the Nova T® 380 study there were seven pregnancies, of which one had a normal delivery. Three were terminated, one had a spontaneous abortion, and two were ectopics. In the levonorgestrel IUS study there were five pregnancies, of which one had a normal delivery, two had a spontaneous abortion, one was a missed abortion and one was ectopic.

It is our intention to publish the 5 year results during 2001.

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References

- 1 Bacon L. The Nova T series of IUDs (letter). *Br J Fam Plann* 2000; 26 (4): 244.
- 2 Cox M, Blacksell S. Clinical performance of the Nova-T® 380 IUD in routine use by the Family Planning and reproductive Health Research Network: 24 month report. *Eur J Contracept Reprod Health Care* 2000; 5: 83.
- 3 Cox M, Blacksell S. Clinical performance of the levonorgestrel intrauterine system in routine use by the Family Planning and Reproductive Health Research Network: 24 month report. *Eur J Contracept Reprod Health Care* 2000; 5: 83.

What indeed is so bad about teenage pregnancy?

Madam,  
First we have to ask what is meant by the term 'teenage pregnancy' and, indeed, what statistics are gathered regarding teenage pregnancy.

The papers reviewed in this article<sup>1</sup> seem to show adverse outcomes mainly below 16 years of age.

If the term 'teenage pregnancy' includes planned pregnancy in 17-19 year old mothers in stable relationships, then many of these are not a major social and medical problem. If the term is restricted to unplanned pregnancies in the teenage years or only pregnancies under the age of 16 years, then I agree that many of these do reflect a major social and medical problem.

I believe more clarity is needed about what exactly the term 'teenage pregnancy' really means. If nationally we are collecting statistics that record both high and low risk groups, then

they are of very little use in planning local services or allocating resources.

K Leeper, MB ChB, MRCGP, DRCOG, DFFP  
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Reference

- 1 Cunnington AJ. What's so bad about teenage pregnancy? *Journal of Family Planning and Reproductive Health Care* 2001; 27 (1): 36-41.

Madam,  
I read with interest the article 'What's so bad about teenage pregnancy'<sup>1</sup> with interest. I have recently completed a review of 267 teenage pregnancies in the York area from 1995 to 2000. Interestingly it was found that there was no increase in the proportion of premature deliveries and that the average birth weight was almost identical to that of the babies of the non-teenagers. There was no increase in maternal admission rate or morbidity.

There were two significant findings. Firstly, the incidence of foetal anomaly was three times higher than normal. This has never been described in another study. There was also found to be an incredibly poor recording of contraception in the antenatal care notes and little mention in the discharge notes of any plans for contraception in the future.

Our overall feeling was that the pregnancies were managed well and that few complications arose. This may be due to the relative affluence of the population of York. But the prevention of pregnancy was poor.

Peter Williams, MB BS, DFFP, CertCLAM  
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Reference

- 1 Cunnington AJ. What's so bad about teenage pregnancy? *Journal of Family Planning and Reproductive Health Care* 2001; 27 (1): 36-41.

Pre-menarchal prescription of Dianette

Madam,  
Standard recommendation is that the combined pill should not be started until after the menarche, since there is a lack of evidence as to the effect an earlier start might have on the pituitary-ovarian axis.

I have just seen a 16-year-old girl in the family planning clinic, who reported that she was started on Dianette at age 12, before her menarche, because of a spotty face. She continued taking it until she was 14.5 years old, and stopped when she changed to tetracycline therapy. She reports no delay in the continuation of regular menses, although they were heavier, without period pain. She attended our clinic at age 15 years and 10 months, weight 50 kg, and was started on the combined pill.

I report this to show that, for one young woman of normal weight, menarche proceeded apparently normally despite therapeutic suppression of ovulation.

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Which intra-uterine device should we favour?

Madam,  
In common with other family planning doctors with their clients' best interests at heart, I am keen to make an intelligent and informed decision as to which IUDs are reasonable and efficient

alternatives to the Gyne T 380 which we believed to have a superior failure rate compared to the other available copper devices. I was therefore interested to read the report on the Nova T 380 from the UK Family Planning Research Network in the July 2000 issue<sup>1</sup> which gave a favourably low failure rate of 0.8 per 100 woman-years at 1 year. The report also quoted seven other studies to provide comparisons between the failure rates of the Nova T(200), Nova T 380 and the Gyne T 380 slimline, which I thought might help me compare the devices with regard to failure rate.

However, on close study of these papers and a Medline literature search on other IUDs I have come to the conclusion that far from the published data allowing us to 'rank' the available devices, they generally show us no statistically significant differences in the failure rates. A serious omission from the tables in this paper (and others in our Journal) are the probability levels that the results quoted achieve statistical significance. In fact these, and many other studies on IUDs, were on sample sizes of 200-1116 women with event rates (i.e.: unintended pregnancy) of 0 to 18, with wide variation between different studies of identical devices. For instance, one study of the much maligned Nova T 200 had the lowest failure rate of all the quoted studies with no failures in the first year (in a sample size of 438 women), which was from our own UK Family Planning Research Network study published in 1989.<sup>2</sup> As recently as 1995 Farr et al reported a comparative study of the Copper T 380A and the Lippes Loop,<sup>3</sup> giving a failure rate of 2.1 for the Lippes Loop and a potentially impressively low rate for the Copper T 380A of 0.7, but with the sample size of 710 the distribution of the handful of pregnancies between the groups was not statistically significant (p = 0.25). In fact it is interesting to note that also in the July Journal the study published on the Mirena IUS had a low pregnancy rate of 0.6 at 12 months, but as this figure is derived from three accidental pregnancies in a sample size of 692 this does not demonstrate a statistically significant improvement on many of the other devices I have mentioned.

I think it is time we look a long hard look at the statistics on which we base our views of the efficacy of the IUDs. We should probably consider that sample sizes for the modern devices which are all relatively effective will need to be much larger (possibly tenfold) if we want to use these studies to look at fine differences in failure rate. In the mean time the most scientific approach to choosing a device from the stock cupboard containing NovaTs, Nova T 380, Multiload 375 and even the odd remaining Gyne T 380 might be to pick one out at random.

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References

- 1 Cox M, Blacksell S. Clinical performance of the Nova 380 IUD in routine use by the UK Family Planning Network. *British Journal of Family Planning* 2000; 26 (3): 143-147.
- 2 UK Family Planning Research Network. A multicentre use-effectiveness study of the Novagard intra-uterine device. *British Journal of Family Planning* 1989; 15: 36-37.
- 3 Farr G, et al. Clinical performance of the Tcu 380 A and the Lippes Loop IUCDs in three developing countries. *Contraception* 1995; 52 (1): 17-22.

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.