

**Contraceptive use among South Asian women attending general practices in south-west London.** Saxena S, Oakeshott P, Hilton S. *Br J Gen Pract* 2002; **52**: 392–395

Five general practices referred 180 consenting South Asian women, who attended daytime consultations, to take part in a structured survey that was available in four languages. The response rate was 95%.

Overall prevalence of contraception was found to be 63%, but this ranged from 70% in teenagers to only 50% in women over 30 years of age whose family was complete.

The termination rate at 13% was lower than overall local rates.

When asked about preferred setting for family planning consultations, 44% had no preference and 36% preferred their general practitioner (GP).

In conclusion, overall use of contraception in this group is low. Most South Asian teenagers were sexually active and apparently able to access contraception.

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**Comparative study and evaluation of side effects of low-dose contraceptive pills administered by the oral and vaginal route.** Ziaei S, Rajaei L, Faghihzadeh S, et al. *Contraception* 2002; **65**: 329–331

This is a comparative study of the side effects and acceptability of low-dose pills administered by the oral and vaginal routes. The rationale for using the vaginal route was to avoid the first pass through the liver. The study was designed to determine if the side effects of the oral contraceptive pills could be reduced by vaginal administration and whether this method of use was acceptable.

A total of 143 women took part in the study. The sample size was estimated with  $\alpha$  and  $\beta$  equal to 0.01 and the significance calculated by the MacNemar test. The women acted as their own controls in the study. They took pills containing 150  $\mu$ g levonorgestrel and 30  $\mu$ g ethinylestradiol orally for three cycles and then after 1 month with no hormones being used, inserted the same formulation vaginally for three cycles. Side effects, including nausea, vertigo, headache, breast tenderness, dysmenorrhoea and gastrointestinal effects, were significantly decreased when the pills were used vaginally ( $p = 0.0001$ ). There was no significant difference for breakthrough bleeding between the two comparison groups.

A total of 79.8% of the women reported that the vaginal method was a suitable method and would use it again. The main reasons that it was discontinued were by objections from the family and difficulty in using the method. As the study comes from Iran, there may be cultural difficulties in using the method that are not mentioned in the report. There was no discussion on the popularity of other vaginal methods in their target population. As the use of vaginal methods of contraception in the UK is low, maybe this method of using the combined pill will only be useful to a select group of women.

Reviewed by **Judy Murty**, DRCOG, MFFP  
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**Bone mineral density at various anatomic bone sites in women receiving combined oral contraceptives and**

**depot-medroxyprogesterone acetate for contraception.** Wanichsetakul P, Kamundhamas A, Watanarungkovit P, et al. *Contraception* 2002; **65**: 407–410

This retrospective study looked at the bone mass density of women using combined oral contraception ( $n = 59$ ), depot-medroxyprogesterone acetate (DMPA) ( $n = 34$ ) or controls ( $n = 62$ ) who had not used steroid contraception for 6 months. The groups were matched for body mass index, age, smoking, alcohol consumption, caffeine consumption and exercise. There was no matching for family history nor was this considered in the exclusion criteria. There was no consideration of the menstrual history of the controls or the DMPA users so there is no record as to whether the DMPA users were amenorrhoeic. The results are given on one measurement of bone density and not on serial readings.

The criterion used for long-term use was 2 years, which does not match with any corresponding retrospective studies. Other papers considered in their discussion gave information from 1 to 5 years. There appears to be no consensus as to what constitutes long-term use. The conclusions of the study showed that bone loss in the DMPA group was only significant for the lumbar spine and no other site. There was no significant affect associated with combined oral contraception.

The authors feel that their study will help to diminish concerns that hormonal contraception has a detrimental affect on bone density but they also recognise that only a prospective study can give a definitive answer. This paper is yet another that gives us a snapshot of women using DMPA and that the bone mass loss may not be as bad as maintained by some authorities, but the paper does not actually give a definitive answer.

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**Extrauterine mislocated IUD: is surgical removal mandatory?** Markovitch O, Klein Z, Gidoni Y, et al. *Contraception* 2002; **66**: 105–108

The article is based on three case studies regarding the possible complications of a copper intrauterine device (IUD) in the peritoneal cavity. The authors have reviewed the literature on the side effects of a copper IUD in the peritoneum after perforation at fitting or a later time. At laparoscopy the three cases discussed did not have any sign of abnormal findings in the peritoneum and were symptomless before surgery.

The article maintains that the guidance from the World Health Organization (WHO) and the International Planned Parenthood Federation (IPPF) are unnecessarily strict in that the lost devices should be removed as soon as the perforation is diagnosed. This is to prevent complications as well as medico-legal problems. Their review of the literature suggests that a copper IUD that is causing no symptoms after perforation can be left alone as the risks of an unnecessary operation are greater. The authors' experience of the three cases seems to support this conservative management plan. There is the potential for complications arising from the laparoscopy. This management strategy would only apply to symptomless cases.

Standard text in the UK advises that at perforation the woman should be referred for laparoscopy. As there is an in-built delay in some parts of the UK for getting an ultrasound scan and referral to hospital, this paper suggests there

is no need for urgency with an uncomplicated perforation. The one concern is how you are going to predict whether there will be a complication or not, and how is the woman going to react if you inform her that the IUD can stay where it is.

The authors call for more research on animal models before advocating the removal of asymptomatic perforated IUDs. I would prefer the scenario of advocating removal of the IUD until evidence shows that it is safe to leave the perforated IUD. Or is that just being too cautious?

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**Detection of Chlamydia trachomatis infection in early pregnancy using self-administered vaginal swabs and first-pass urines: a cross-sectional community-based survey.** Oakeshott P, Hay P, Hay S, et al. *Br J Gen Pract* 2002; **52**(483): 830–832

Chlamydia detection and screening is part of the sexual health and HIV strategy and has become a concern of primary care doctors. Its importance in pregnancy is related to neonatal transmission, causing conjunctivitis and pneumonitis. This is the first study, based in primary care, which looks at detection in pregnancy. The study was designed not just to look at the prevalence of chlamydia, but also evaluate the use of self-administered vaginal swabs and first-pass urine.

The study used 32 general practices and five family planning clinics in South London, recruiting consecutive pregnant women who were less than 10 weeks' gestation. They were requested to provide a self-administered vaginal swab and urine sample on that day, and at 16 weeks they filled in a postal questionnaire with further details including how they felt about providing the samples. They recruited 1216 participants and had paired specimens available for 1161 women.

*Chlamydia trachomatis* was tested for by ligase chain reaction, positive results being confirmed by direct immunofluorescence. The study found the overall prevalence of infection was 2.4% (95% CI 1.5–3.3). In women aged under 25 years it was 8.6% (95% CI 4.1–12.9) and in pregnant teenagers it was 14.3% (95% CI 3.7–24.9).

The most important aspect of this study was that women were prepared and capable of taking their own swabs. Having said that, 47% of responders said they preferred providing a urine specimen, but 48% of responders expressed no preference.

This study shows how effective self-administered tests can be in community screening. The limitations of the study are important. Only 28 women had positive specimens and the study was not designed to evaluate sensitivity and specificity. The exclusion of those requesting termination may have altered prevalence rates. However, the rates of infection are similar to those found by other community studies.

The study demonstrated that non-invasive tests are feasible and acceptable in a community setting. It would be essential for the implementation of any national screening programme also to show that the tests are sensitive and specific.

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