Attitudes towards pelvic examination and chaperones: a questionnaire survey of patients and providers. Fiddes P, Scott A, Fletcher J, et al. *Contraception* 2003; **67**: 313–317

This helpful paper looks directly at women's feelings about pelvic examination and their attitude towards chaperones being present during examination. It also reports on doctors' contrasting opinions in this area.

This study was designed in response to guidelines from UK professional bodies on intimate examinations. The Royal College of Obstetricians and Gynaecologists guideline recommends the routine presence of a chaperone regardless of the doctor's gender.[1] The Faculty of Family Planning and Reproductive Health Care (FFPRHC) has responded with guidance more appropriate to the community setting, where many doctors are female and many patients probably do not want a chaperone during intimate examination. They recommend all patients should be aware that they can request a chaperone if they wish.[2]

In this study 1000 women attending family planning clinics (FPCs) were asked to complete patient questionnaires; the response rate was 69%. Half of the respondents were aged between 21 and 40 years, with only 8% aged under 21 years and the remainder being over 40 years. Provider questionnaires were given to 98 doctors attending a family planning update seminar in Edinburgh. Their response rate was 90%. Only 11% of providers were male. Just over half the providers worked in general practice, 19% in family planning, and the remainder were hospital specialists, mostly in genitourinary medicine or gynaecology.

Most women were less concerned about pelvic examination than doctors predicted; 17% of under 25-year-olds and 21% of over 25-year-olds said they did not mind and would not expect to find the procedure unpleasant. Two-thirds of women saw pelvic examination as somewhat unpleasant but tolerable. Only 23% of under 25-year-olds and 12% of over 25-year-olds felt anxious or distressed at the prospect and might even refuse examination. Most doctors predicted women would find pelvic examination unpleasant but tolerable.

On preferences for gender of the doctor, 20% of women said they would only accept a female, 56% would prefer a female, 24% had no preference and 1% would prefer a male doctor. If the examining doctor was female, 11% of women would prefer a chaperone, 34% would rather not have a chaperone and 55% would have no preference. When the examining doctor was male, 62% of women would want a chaperone, 9% would prefer no chaperone and 29% did not mind. Amongst providers, only 10% preferred the presence of a chaperone, most of these being males, who routinely used chaperones.

These results should be interpreted in light of the population studied; many women attend FPCs specifically to see a female doctor. Nevertheless these are important data to support the FFPRHC's guidelines to offer but never impose a chaperone during intimate examination by female doctors in the community setting. Most women in this study would want a chaperone when a male doctor examines them, but not when a female doctor examines them. This has important resource implications for FPCs where universal use of chaperones would be costly and time-consuming.

References
1 Royal College of Obstetricians and Gynaecologists (RCOG). *Intimate examinations, report of a working party.* London: RCOG, 1997.
2 Randall S. Intimate examinations. *Br J Fam Plann* 1998; **24**: 83–84.

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Smoking, body mass and hot flashes in midlife women. Whiteman MK, Staropol CA, Langedberg PW, et al. *Obstet Gynecol* 2003; **101**: 264–272

Gabapentin's effects on hot flashes in postmenopausal women: a randomised controlled trial. Guttuso T, Kurlan R, McDermott MP, et al. *Obstet Gynecol* 2003; **101**: 337–345

Recent large randomised trials have made us re-evaluate the indications for hormone replacement therapy (HRT) and have increased interest in prescribing non-hormonal alternatives for vasomotor symptoms. These two studies published in the same journal raise interesting concepts relating to menopausal symptoms.

The cross-sectional study by Whiteman and colleagues suggests that lifestyle factors such as smoking and a high body mass index (BMI) may predispose a woman towards more severe or frequent hot flushes. Over 1000 US women aged between 40 and 60 years participated in a mailing survey entitled 'Study of Women's Health in Midlife'. Detailed hot flush and smoking histories were obtained together with extensive demographic information. BMI was calculated from self-reported height and weight at the time of the survey.

Current smokers had 1.9 times the odds of never smokers for reporting moderate to severe hot flushes (95% CI 1.3–2.9). High BMI (>30 kg/m^2) was also associated with an increased risk of moderate to severe vasomotor symptoms with an adjusted odds ratio of 2.1 (95% CI 1.5–3.0) compared to women with low BMI (<24 kg/m^2). The cross-sectional nature of this study limits the conclusions that can be drawn and the authors emphasise the need for prospective studies in this field. However, smoking and high BMI are both potentially modifiable risk factors and this study may give the clinician some authority to persuade women to improve their general lifestyle.

Guttuso and colleagues evaluated the role of the anti-epileptic agent, gabapentin, in the treatment of menopausal symptoms in a small, 12-week randomised trial. Gabapentin at a dose of 900 mg/day was associated with a 45% reduction in hot flush frequency and a 54% reduction in hot flush composite score (frequency and severity combined), compared with 29% and 31% reductions, respectively, for placebo. A total of 54 women completed the double-blind study, although four women (13%) withdrew from the gabapentin group and half the women in that group reported at least one adverse effect. Side effects included drowsiness and dizziness, although the authors claim these effects can be minimised by gradual titration of the initial dose. The mode of action of gabapentin in reducing hot flushes is unknown, although it is known to have an anxiolytic effect and the potentially sedative role may have reduced perception of night sweats. We need more agents to treat menopausal symptoms in women with contraindications to HRT or who feel that they have taken HRT in the long term and desire an effective alternative. Gabapentin shows good potential in this regard. Ongoing studies will provide further good quality clinical data and gabapentin should probably be used only with caution for this indication.

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Choices about abortion methods: assessing the quality of patient information leaflets in England and Wales. Wong S, Bekker H, Thornton J, et al. *Br J Obstet Gynaecol* 2003; **110**: 263–266

The authors, from Leeds, point out the important recommendation of the Royal College of Obstetricians and Gynaecologists (RCOG) that accurate, impartial, printed information should be used to support verbal advice to anyone contemplating a legal abortion (RCOG Evidence-Based Guidelines, No 7, 2000).

They examined 44 leaflets that included advice regarding medical and/or surgical methods. These included leaflets from the three largest private abortion organisations in England and Wales together with leaflets provided by 41 National Health Service (NHS) hospitals. However, 16/60 providers contacted did not use leaflets at all. A total of 28/44 leaflets dealt with both surgical and medical methods. Each was assessed using a coding frame with points awarded for each item of information deemed relevant by the investigators. There seems to have been little attempt at loading the score according to the relative importance of each item.

The results were disappointing. Of the leaflets that discussed surgical methods, 60% scored less than half the possible score for that method, and of those that discussed medical methods, 34% scored less than half the possible score. Of those that discussed aftercare, 23% scored less that half the possible score.

They also assessed the leaflets according to the Flesch Readability Ease scale. The results were as follows: 2% scored Difficult (equivalent to the *Financial Times*), 52% scored Fairly Difficult (*Daily Telegraph*), 41% scored Standard (*Daily Mail*) and 5% scored Fairly Easy (*The Sun*).

The authors comment that most of the leaflets contained incomplete information and were difficult to understand. They conclude that it is unlikely that the leaflets enabled women to make informed choices about their treatment options and/or prepare for subsequent procedures. Their main recommendation is that 'abortion services should provide complete, accurate, relevant and unbiased written information about abortion method choices ... this information should be informed by guidelines on the aims, benefits, risks and procedures of each abortion method and assessed for readability'.

These comments and recommendations seem eminently reasonable. It is particularly disappointing that many hospitals provide no leaflets. There is considerable room for improvement but how is this to be achieved? The construction of a leaflet to the high standards advocated in this paper is not at all easy. Probably the required expertise does not exist in every providing hospital or organisation. At present every provider who thinks of having a leaflet has to 'invent the wheel again'! Would a nationally agreed leaflet be possible and desirable? Could the FPA provide such a leaflet? The present FPA leaflets, *Abortion, your questions answered* and *Abortion, just so you know*, are excellent. They concentrate on helping women to decide what to do and how to do it rather than on a comprehensive discussion of each method. For those who may at this time be thinking of 'inventing the wheel' for their own hospital, you could not do better than to consult the abovementioned RCOG Guidelines, and the FPA leaflet, *Abortion, your questions answered*, and, in my opinion, consult also the leaflets produced by the British Pregnancy Advisory Service (BPAS) and/or Marie Stopes International.

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