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References

- 1 FFRHC Clinical Effectiveness Unit. New Product Review (April 2003). Desogestrel-only pill (Cerazette). *J Fam Plann Reprod Health Care* 2003; 29(3): 162–164.
- 2 Foy R, Crilly M, Brechin S. Evidence-based reproductive health: testing times for treatments. *J Fam Plann Reprod Health Care* 2003; 29(3): 165–168.
- 3 FFRHC Clinical Effectiveness Unit. FFRHC Guidance (July 2003). Contraceptive choices for women with inflammatory bowel disease. *J Fam Plann Reprod Health Care* 2003; 29(3): 127–135.
- 4 World Health Organization (WHO). *Medical Eligibility Criteria for Contraceptive Use*. Geneva, Switzerland: WHO, 2000.

New GyneFix® introducer

Madam

We wish to share our experience with using the new GyneFix® introducer.

The Abacus Centre in Liverpool was the first service to offer the frameless intrauterine device, GyneFix in the UK, when it was introduced in

1997. To date we have fitted 1750 of these devices. Our audit of the first 100 insertions showed we had 11 failed insertions (of the 1000). Since the introduction of the new GyneFix introducer in our service in early 2002, we had anecdotal reports of failed insertion by all doctors carrying out insertions in our service. Initially we considered this to be part of the learning curve with the introduction of any new technique. However, when the failed insertions continued, we undertook an audit of failed GyneFix insertions from January 2003 to August 2003. During this period there were 50 attempted GyneFix insertions of which 38 were successful and 12 failed to anchor the device. In 7/38 successful insertions, there was more than one attempt to implant the GyneFix. We wasted 18 devices during the 50 attempted insertions. There was no indication that doctors with greater experience in GyneFix fitting had fewer failed insertions compared to those who had fitted fewer devices. This has raised difficulties in our counselling of women for GyneFix insertions as well as in our ability to continue to offer it as part of our contraceptive menu. We have reported these failed insertions to the manufacturer. We have heard from them that they have decreased the thickness of the tail of the inserter, which may reduce this problem. However, this modification is only in the GyneFix 200, which only has four beads and for which there are few published long-term data.

We will be very interested to hear from other services as to whether they are experiencing similar problems with the new GyneFix introducer.

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NEWS ROUNDUP

A new IT solution for sexual health?

Information technology (IT) has been promoted as a panacea for all ills and sexual health is no exception. The technological boom is here to lend a helping hand to deal with the current sexual health crisis facing the country! The IBM partner, Appareo, aims to provide an effective, national, specialist, sexual health performance management system based around a data warehousing approach. The two critical elements are personal client data and clinical data and application.

The director assures us that the system will cater to the requirements of the national IT strategy and health care clinicians. Other benefits proposed are reduction in waiting times, improved patient access and an annual savings of £9 million.

The infrastructure needs to be clarified, in terms of the staff, resources and training. Should the responsibility for its smooth functioning rest with the already burdened clinicians or with new staff (with an added cost implication)? These issues warrant exhaustive thought before the adoption of such a system. For more details contact beyondpr@blueyonder.co.uk.

New national standards for HIV and AIDS care

Funded by the Department of Health, these standards were drawn up in line with the National Strategy for Sexual Health and HIV.¹ The Medical Foundation for AIDS and Sexual Health (MedFASH), a charity sponsored by the British Medical Association, is publishing the standards. They cover all aspects of HIV care from prevention and diagnosis to palliative care. Each of the 12 standards is accompanied by the evidence base and lists the key interventions. They include the implications for service

planning, guidelines for administrative and clinical practice, as well as suggestions of how to audit what is provided. The main challenge will be how to implement these excellent standards. Primary care organisations may find the standards difficult to fund and implement because of competition with other areas, better funded, or more socially acceptable such as coronary heart disease. The standards can be downloaded from www.medfash.org.uk.

Reference

- 1 National Strategy for Sexual Health and HIV. <http://www.doh.gov.uk/sexualhealthandhiv/index.htm>

Changes to cervical cytology screening

Liquid-based cytology will now be the preferred method of examination. In this method of screening the sample is collected from the cervix in the same way, but using a special plastic broom-like device which is swept over the transitional zone five times to collect cellular material. The broom is rinsed or broken off in a vial of preservative. The vial is mixed in the laboratory and treated to remove unwanted material by an automated process. The remaining suspension of cells can be stained and the prepared slide looks much clearer for examination. The number of unsatisfactory (inadequate) slides is reduced and fewer women will be made anxious by being recalled.

The frequency of screening will also be changed to a more equitable system. All women, wherever they live, are to be screened every 3 years from the age of 25–49 years, and then every 5 years until the age of 64 years. Further information is available at www.nice.org.uk.

Male contraception

Health professionals may have been perplexed by reports in the media about 'The risk-free pill for men' (*Daily Mail*) or 'Male birth control pill successfully tested' (*The Daily Telegraph*). These

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Reference

- 1 Dennis J, Webb A, Kishen M. Expulsions following 1000 GyneFix insertions. *J Fam Plann Reprod Health Care* 2001; 27(3): 135–138.

Dieting and breakthrough bleeding on COCs

Madam

When dealing with the Margaret Pyke postbag, I was interested to receive a couple of queries requesting advice on the development of breakthrough bleeding (BTB) on combined oral contraceptives (COCs) in women who had had a regular bleeding pattern until they went on diets and lost a lot of weight quite quickly. In one case, the Atkins diet (high protein, low carbohydrate) had been followed; in another, the woman was using Lighter Life® meal replacements. All other causes of BTB had been excluded.

I would be interested to know if other readers have come across this phenomenon and if I should add a question about dieting and weight loss to my list for women who present with BTB.

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newspapers had picked up on a report from Australia that showed no pregnancies in the partners by the end of 12 months. The men received an injection of 150 mg depot medroxyprogesterone acetate every 3 months, together with an implant of 800 mg testosterone every 4 months. No serious side effects such as weight gain or hypertension were recorded in the 55 men studied. All male methods requiring sperm suppression have a long lead-in period, of course. It will be interesting to see if larger studies are as free from problems, such as mood swings or loss of libido, which have limited previous studies of this combination of therapies. Further information on male contraception is available from www.malecontraceptives.org.

Four periods a year

Seasonale® has been approved by the Food and Drug Administration in the USA. It contains levonorgestrel and ethinyl oestradiol and is taken consecutively for 84 days, followed by seven pill-free days to produce a withdrawal bleed. Trials showed a similar effectiveness to conventional combined oral contraceptives. Some of the comment surrounding this alternative has suggested that it is healthier to avoid menstrual loss, a statement that cannot be backed up by evidence at present. Making Seasonale available will expand women's contraceptive options and increase convenience for some. This advance should not be undermined, however, by over-promising and over-promotion or by stigmatising menstruation. More information is available from www.womenshealthnetwork.org.

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