The Internet, a simple and convenient tool in *Chlamydia trachomatis* screening of young people. Novak DP, Edman AC, Jonsson M, et al. *Euro Surveill* 2003; **8:** 171–176

A study in Sweden using the Internet to promote chlamydia screening claims the highest male participation rate published to date, as well as reaching young men outside the usual high-risk groups. The participation rate was 38.5% among 22-year-olds in a small university city. The men were sent a package containing a cover letter, a urine specimen container and a questionnaire about social and sexual behaviour. The participants could return the sample and questionnaire in a prepaid, pre-addressed, biological substance envelope. Two reminders were sent. The participants obtained the test results from a website, which also provided information about chlamydia and gave relevant Internet links for more information about other sexually transmitted infections. For study participants without access to a computer, a phone number was provided so that they could call the testing centre and obtain their results. The only person who did not obtain his results did not understand the instructions and had to be contacted personally. The small number of participants did not allow for the prevalence rate to be established – only 1.1% had positive tests – but the low rate suggests that men outside the usual high-risk groups had been reached.

Follow-up questionnaires were sent to non-responders and reasons for not participating included recent testing or never having had sexual intercourse. The worrying group of the non-participants were those who stated that they did not care (25.5%) or believed that they were not infected (50%). The lack of anonymity required by Swedish law might also have had an inhibitory effect.

This use of the Internet for involving young people shows promise in extending screening beyond the restricted vision of targeting women attending health care premises or traceable contacts of identified cases.

Reviewed by **Gill Wakley**, MD, MFFP
Visiting Professor in Primary Care Development, Staffordshire University and Freelance GP and Writer, Abergavenny, UK

Detection of raised FSH levels among older women using depomedroxyprogesterone acetate and norethisterone enanthate. Bekinska ME, Smit JA, Kleinschmidt I, et al. *Contraception* 2003; **68:** 339–343

It is difficult to advise when women using injectable progestogens can stop because they have become postmenopausal. The use of depomedroxyprogesterone acetate (DMPA) or norethisterone enanthate (NET-EN) inhibits the mid-cycle surge of follicle stimulating hormone (FSH) and luteinising hormone (LH).

This study was an observation from a cohort study designed principally to look at the affect of hormonal contraception on bone density. Women were also included at varying lengths of use of the injectable methods. A total of 117 DMPA users and 60 NET-EN users were compared with 161 non-users. A blood sample was taken to determine the FSH and LH levels at entry to the study. If the first sample was taken within the first 30 days of one injection, another sample was taken 80 days after that injection.

The results appeared to show a linear association between the FSH and LH levels with the age of the women and not to the length of time on the injections. The FSH and LH levels were suppressed in the first 30 days after the injections. Raised FSH and LH levels were found in menopausal women at the time just before the next injection. The authors are suggesting that it should be possible to detect the menopause by measuring FSH and LH levels as late as possible before the next injection.

There are concerns about the study. First, this was a subsidiary outcome of the study undertaken. The authors acknowledge that the laboratory used for assaying the FSH and LH levels had not set their own calibrations for the tests. However, they have shown that it was possible to detect the menopause in some women receiving DMPA and NET-EN. Menopausal levels on a blood test taken just before the next injection may be useful but low levels of FSH/LH may only indicate suppression by the injectable contraceptive.

Reviewed by **Judy Murty,** DRCOG, MFFP
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Randomised controlled study comparing oral and vaginal misoprostol for cervical priming prior to surgical termination of pregnancy. Ashok PW, Hamoda H, Nathani F, et al. *Br J Obstet Gynaecol* 2003; **110:** 1057–1061

Vaginal misoprostol is known to be an effective cervical priming agent. However, the minimal evacuation interval is 3 hours, which can be difficult to achieve in day case surgery. Studies have suggested that orally administered misoprostol is less effective than vaginal misoprostol, but it offers the advantage of self-administration at home.

This randomised, controlled study involved 64 women randomised to receive misoprostol 400 mg orally at home or vaginally in hospital 2–4 hours before surgical termination of pregnancy. There was no significant difference in the force required to dilate the cervix, the operating time or the blood loss. Oral misoprostol was associated with a significantly longer priming to abortion interval, and was more likely to cause nausea. Although previous studies have suggested that women prefer to take misoprostol by mouth, this study showed similar patient acceptability with the two routes of administration. However, the majority (83%) of nursing staff preferred the oral route.

The study suggests that oral administration of misoprostol before surgical termination is feasible and acceptable to both patients and nursing staff. The authors comment that vaginal self-administration would be an alternative method that needs to be assessed.

Reviewed by **Louise Melvin,** MRPharmS, MRCOG
Specialist Registrar in Obstetrics and Gynaecology, Centre for Reproductive Biology, Edinburgh, UK

ERRATA

'FFPRHC Guidance on The Copper Intrauterine Device as Long-term Contraception (January 2004)', *J Fam Plann Reprod Health Care* 2004; 30(1): 29–42

The Clinical Effectiveness Unit (CEU) wishes to apologise for a number of errors that appeared in the abovementioned Guidance document.

On page 32, in the section on Efficacy, in the second and third paragraphs the expression 'per 100 woman-years' was incorrectly substituted for the expression 'per 100 women'. The correct text appears below and on the Faculty website at www.ffprhc.org.uk.

WHO states that an IUD (in particular the T-Safe® Cu380A) is a very effective method, with 0.6–0.8 pregnancies per 100 women in the first 12 months of use.[4] Three of the largest WHO randomised trials investigated T-Safe® Cu220C, Multiload® Cu250, Nova-T® and T-Safe Cu380A devices in parous women recruited from 24 centres in 14 countries.[32] The T-Safe Cu380A had the lowest cumulative pregnancy rate. A follow-up study included 7159 woman-years for the T-Safe Cu380A and 17 098 woman-years for the T-Safe Cu220C.[33] The T-Safe Cu380A had a significantly lower cumulative pregnancy rate after 8 years (2.2 per 100 *women*). Indirect comparisons with 10-year failure rates for tubal sterilisation[34] (1.9 per 100 *women*) suggest that T-Safe Cu380A may be an effective alternative to sterilisation. The WHO studies included parous women only. The 1-year failure rate for T-Safe Cu380A in nulliparous women was 1 per 100 *women*.[35] An adaptation of the T-Safe Cu380A (T-Cu380S Slimline®) has not been shown to alter pregnancy rates.[36]

A 3-year randomised trial compared T-Safe Cu380A with Multiload® Cu375 in parous women. Pregnancy rates were low for both devices, but significantly less for the T-Safe Cu380A (1.6 compared to 2.9 per 100 *women*).[37] A review of four studies comparing Multiload Cu375 with T-Safe Cu380A in parous women also identified lower pregnancy rates for T-Safe Cu380A.[38] Phase III clinical trials of Nova-T® 380 identified similar cumulative pregnancy rates of 1.9 per 100 *women* at 5 years.[39,40]

In the same Guidance document, on page 38, in Recommendation 44 (in the red box), the word 'Asymptomatic' should have appeared rather than 'Symptomatic'. The correct text reads as follows:

44	**Asymptomatic IUD users with ALOs detected on a cervical smear should be advised there is no reason to remove the IUD unless signs or symptoms of infection occur (Grade B).**

The CEU wishes to apologise for any confusion these inadvertent errors might have caused readers.