Issues surrounding the insertion of intrauterine contraception postpartum, when the uterus is involuting, are clearly different from first-trimester abortion but may be more similar to second-trimester abortion. However, in the absence of evidence the CEU advised that, as for postpartum insertion, following medical abortion the insertion of intrauterine contraception should be within the first 48 hours or delayed until 4 or more weeks after abortion. This advice from the CEU may be too restrictive but until more published evidence is available an alternative recommendation cannot be made. The CEU would certainly encourage groups to publish their case series of post-abortion IUD insertions (Level III evidence) to increase the evidence base.

Susan Brechin, MRCOG, MFFP
Co-Ordinator, Clinical Effectiveness Unit, Faculty of Family Planning and Reproductive Health Care, Room 63, Aberdeen Maternity Hospital, Cornhill Road, Aberdeen AB25 2ZD, UK

References
1 FFPRHC Clinical Effectiveness Unit. FFPRHC Guidance (January 2004). The copper intrauterine device as long-term contraception. *J Fam Plann Reprod Health Care* 2004; **30**(1): 29–42.
2 Grimes D, Schulz K, Stanwood N. Immediate postabortal insertion of intrauterine devices. In: *The Cochrane Library*, Issue 4, 2003. Chichester, UK: John Wiley & Sons.
3 World Health Organization (WHO). *Medical Eligibility Criteria for Contraceptive Use*. Geneva, Switzerland: WHO, 2000.
4 Heartwell S, Schlesselman S. Risk of uterine perforation among users of intrauterine devices. *Obstet Gynecol* 1993; **61:** 135.

JOURNAL CLUB

Implanon – the single-rod subdermal contraceptive implant. Newton J, Newton *P. J Drug Eval* 2003; **1**(6): 177–218. Parthenon Publishing Group. ISSN 1479-1137

This relatively new journal is primarily aimed at pharmaceutical physicians, but its Editor-in-Chief, Professor Ronald Mann, hopes it will also be useful to clinicians. Each issue is devoted to examining a single drug, with the intention of doing so in an independent and comprehensive manner. The Editor-in-Chief writes an 'executive summary' derived from the review.

Authors are selected on the basis of their extensive clinical experience, but are professionals who are not directly or indirectly associated with the manufacturer in a way that would prejudice independence of view and a declaration of 'conflict of interest' is required to be signed by each author.

The definition for a systematic review was given in an article in the journal in January 2004:[1] 'A critical synthesis of research evidence, which involves analysis of all available and relevant evidence in a systematic, objective and robust manner.' However, this article is not so much a systematic review as a monograph, the definition of which is 'a scholarly book, article or pamphlet on a specific and usually narrow subject'. In many ways it demonstrates the reasons why having specified guidelines is a good idea.

1. What is the research question?
This is not stated explicitly. It could be to answer the question: 'Is this contraceptive method acceptable, effective and safe?' If so, then to a large degree the question is answered, but the answers need to be extracted from a large mass of data. If the question was 'What is known so far about this method of contraception?', then again most of the answers are there, but see the caveats highlighted below.

2. Why was the review needed?
The last review of Implanon that I could find was in 1999,[2] so another is due. This paper is cited twice in this journal (references 29 and 56).

3. Is there a protocol outlining the review specifications? How were sources of literature identified?
The authors do not give their inclusion criteria or their searching protocol, so that it is not possible to judge for degree of bias in selection of papers or the reason for exclusion of papers. I found, on a superficial search, a list of 159 research articles on Implanon – but looking at the abstracts of some of them (it is very time consuming doing a systematic review!) several are obviously not suitable for a review article and some are repeated references.

4. Is there an assessment of the methodological quality of the articles included in the review?
The review includes a summary of the paper by Edwards and Moore[2] that did spell out the inclusion criteria for the studies in that paper (up to 1999). I could not find a similar list of inclusion criteria for papers published after that date, although there only appear to be eight citations after that date.

5. Was a data extraction form used? Was there any independent data extraction?
This is unknown but seems unlikely with only two named authors.

6. Were the data summarised and tabulated with synthesis of results?
Much of the data were summarised but is difficult to access in a systematic way.

7. Is the interpretation valid and the implications for practice considered?
The implications for practice are not contentious and contain no surprises.

In summary, this article may provide a useful resource for those who want information on Implanon gathered together and presented with supporting references. However, clinicians might also want to look at a health technology assessment produced for the National Health Service research and development programme in 20003 that is easily found from the National electronic Library of Medicine (NeLM).[4] Neither this nor a review from the Centre for Reviews and Dissemination[5] of an economical analysis of Implanon are cited. A Cochrane Review protocol has been developed: 'Subdermal implantable contraceptives versus other forms of reversible contraceptives as effective methods of preventing pregnancy', so a systematic review will be available in due course.

References
1 Bruce J. Reviewing the literature: adopting a systematic approach. *J Fam Plann Reprod Health Care* 2004; **30**(1): 13–16.
2 JE Edwards, A Moore. Implanon: a review of clinical studies. *Br J Fam Plann* 1999; **4:** 3–16.
3 French R, Cowan FM, Mansour DJA, et al. Implantable contraceptives (subdermal implants and hormonally impregnated systems) versus other forms of reversible contraception: two systematic reviews to assess relative effectiveness, tolerability and cost-effectiveness. *Health Technol Assess* 2000; **4**(7): i–vi, 1–107. http://www.ncchta.org.
4 http://www.nelh.nhs.uk/.
5 http://agatha.york.ac.uk/online/nhseed/20008111.htm.

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

Clinical outcomes and costs with the levonorgestrel-releasing intrauterine system or hysterectomy for treatment of menorrhagia. randomized trial 5-year follow-up. Hurskainen R, Teperi J, Rissanen P, et al. *JAMA* 2004; **291:** 1456–1463

This study is from all five university hospitals of Finland. In some countries the levonorgestrel-releasing intrauterine system (LNG-IUS) is licensed and/or being used to treat menorrhagia. The commonest indication for hysterectomy is menorrhagia, so it is important to consider whether possible alternatives to surgery are effective and cost-effective.

This study gives the 5-year results of a previously published 1-year study.[1] Of 236 women referred to the hospitals with menorrhagia, 119 were randomised for LNG-IUS treatment and 117 for hysterectomy. Only 12 women failed to complete the 5-year follow-up. The Health-Related Quality of Life (HRQL) was measured using the five-dimensional EuroQol system and the RAND 36-item system. The Spielberger Anxiety Inventory, the Beck Depression Inventory and the McCoy Sex Scale were all assessed. Overall satisfaction was assessed by a five-level question.

Cost analysis was calculated taking account of medical treatment, sick leave, and so on based on Finnish costs. Results at 5 years showed that the two groups did not differ substantially in terms of the HRQL; 94% of the LNG-IUS group and 93% of the hysterectomy group were satisfied or very satisfied. The haemoglobin and serum ferritin levels were significantly higher at 5 years than at base line, with no substantial difference between the groups. However, 50 (42%) women in the group allocated to the LNG-IUS eventually underwent hysterectomy. Of the 57 women with an LNG-IUS in situ at 5 years, 75% reported amenorrhoea or oligomenorrhoea and 19% reported irregular bleeding. In the group allocated to hysterectomy, 109/117 had hysterectomy. Complications included three bladder perforations and one bowel perforation.

The average total cost was US$2817 in the LNG-IUS group and US$4660 in the hysterectomy group, i.e. the LNG-IUS costs were 40% less. When hysterectomy costs are placed at 20% less or placed higher than USA costs, the LNG-IUS costs were still considerably less.

In Finland the use of hysterectomy has been falling while the use of the LNG-IUS has been increasing. The authors conclude the LNG-IUS may improve HRQL at relatively low cost despite the need for some women to eventually require hysterectomy.

The study certainly confirms the LNG-IUS as an effective treatment for menorrhagia. This being the case it is puzzling why *Clinical Evidence*[2] describes it as being of 'unknown effectiveness'. All the more surprising when their own supporting literature review amply confirms its effectiveness! Probably their failure to endorse the LNG-IUS is because there has never been a randomised controlled trial of the LNG-IUS versus placebo, which of course can never occur.

References
1 Hurskainen R, Teperi J, Rissanen P, et al. Quality of life and cost-effectiveness of levonorgestrel-releasing intrauterine system versus hysterectomy for treatment of menorrhagia. *Lancet* 2002; **357:** 273–277.
2 Godlee F (exec. ed.). *Clinical Evidence Concise. 9th Issue. Women's Health Section*. London, UK: BMJ Publishing Group, June 2003; 393. http://www.nelh.nhs.uk/clinicalevidence.

Reviewed by **Michael Cox,** FRCOG, MFFP
Consultant Obstetrician and Gynaecologist (Retired), Nuneaton, UK

Preconception care practice and beliefs of primary care workers. Heyes T, Long S, Mathers N. *Fam Pract* 2004; **21:** 22–27

The authors explored the views of health practitioners working in primary care in Barnsley Health Authority (in the north of England) about preconception care. They obtained a response rate of 61% from general practitioners (GPs), practice nurses, health visitors and midwives in July 2000. Most of those who replied were providing preconception care on an opportunistic basis and infrequently. Few general practices had any written policy. The respondents agreed that advice on smoking, drug use, folic acid, genetic counselling, chronic disease, alcohol and screening was important. Screening advice included rubella, genital infections, hepatitis, human immunodeficiency virus and cervical screening. They felt that advice about diet, exercise, supplements, food safety, occupational hazards and state benefits were less important. Giving preconception advice was not a high