

## Conference Report/Letters



**Figure 3** *The Journal of Family Planning and Reproductive Health Care exhibition stand at the Congress (photograph courtesy of Michael Cox)*

proceedings included a fine exposition by David Baird of the considerable debt that we owe to the contribution of many Scots to the humanities and natural sciences.

The theme of this Congress was holism as applied to family planning and sexual health. We discovered that holism cannot easily be translated into several European languages and indeed is a new concept to many. Part of the definition provided for delegates was: "Holism, philosophically, is the concept that the whole is greater than the sum of its parts. The idea that human well-being, physical and mental, is inextricably linked and requires a holistic approach is nowhere more obvious than in sexual health".

Presentations ranged from keynote speeches from distinguished speakers to short free communications and posters. More than 800 authors contributed to the Congress. An important component of these Congresses is the 'meet the experts' sessions in which discussion takes place in small groups. These proved to be so popular that

some had to be repeated. The Congress also featured a commercial exhibition at which the *Journal of Family Planning and Reproductive Health Care* was represented (Figure 3).

It is impossible to adequately review so many contributions, especially as it is not possible to attend more than a few of the presentations in person. However, I will mention Professor Jim Drife who reminded us of the late Professor Sir Dugald Baird's very relevant addition to the now-classic four freedoms of President Roosevelt: freedom of speech and worship and freedom from fear and want – the addition being freedom from the tyranny of excessive fertility.

The social programme included a cycling tour for those who could manage the hills of Edinburgh and a pub tour for those who couldn't! No doubt many visitors new to Edinburgh had a chance to admire this fine city, its superb castle and other historic buildings – not forgetting the shops. The Royal Yacht at Leith was also an attraction.

A splendid conclusion to the Congress was the Scottish Evening held at the very impressive Royal Museum. The lavish banquet included haggis (not compulsory!). This was followed by a traditional Scottish ceilidh with demonstrations by expert Scottish dancers to help the inexperienced.

Opinions which I heard included "the best Congress ever" from an English doctor and "it's too expensive" from an East European doctor. Both statements are true. Could the ESC manage to sponsor a certain number of East Europeans to future Congresses perhaps?

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#### Editor's Note

Abstracts of the keynote speeches, sponsored symposia, free communications and poster presentations delivered at the 2004 Congress can be viewed on the ESC website at <http://www.contraception-esc.com>.

## LETTERS

### Condom use

Madam

I read with interest the article on 'Condom use amongst men and women attending a genitourinary clinic' published recently in your journal.<sup>1</sup> While the majority of the respondents to the author's questionnaire were aware of condoms, using them was erratic and only sometimes. This is similar to the findings in a study in 2002 from our institution.<sup>2</sup> We found that men and women who reported condom use also had more sexual partners than those who did not report condom use. The incidence of bacterial sexually transmitted infections (STIs) (gonorrhoea and chlamydia) was higher in women who did not use condoms but the incidence of genital warts was higher in those who reported condom use.

During the annual Condom Week (May) and AIDS Day (December) there are concerted campaigns to encourage people to practise safer sex, and condom use is one of the components of this practice. The use of condoms is an acquired practice and is a skill that needs to be learnt. I am of the opinion that many people, whether they attend the genitourinary medicine (GUM) clinic or not, have heard of condoms. It is not from lack of knowledge, but attitude and practice do not synchronise. I wish to suggest that condom manufacturers make more readily available, video demonstrations of 'How to Use a Condom'.

These videos can then be used at family planning clinics, GUM clinics and young people clinics, and so on, for teaching purposes. The incidence of STIs is high among teenagers and condom use is low within this group. Health care workers involved in the care of young people should continue to explore ways of encouraging young people to use condoms properly.

Finally, it should be realised that condom use is one facet of the 'ABC Approach: abstinence, be faithful and condoms'. If young people need sex education, then it is not too soon to teach them about commitment.

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#### References

- 1 Handy P. Condom use amongst men and women attending a genitourinary medicine clinic. *J Fam Plann Reprod Health Care* 2004; 30(3): 159–162.
- 2 Opaneye A. Condom use and sexually transmitted infections. *Sex Health Matters* 2002; 3: 70–72. <http://www.sexualhealthmatters.com>.

### Emergency contraception: latest changes

Madam

At first glance, this commentary<sup>1</sup> appears to carefully appraise the UK's 2004 approach to emergency contraception (EC). On closer inspection, however, there are a few practice issues that require further clarification. Although there are several reports confirming the continued efficacy of hormonal methods of EC up to 120

hours and the IUD up to 7 days, there are good data to show that the effectiveness of EC decreases over time.<sup>2</sup> The Task Force on Postovulatory Methods of Fertility Regulation showed decreasing effectiveness of EC beyond 72 hours after intercourse.<sup>2</sup> This was particularly noticeable within the progestogen-only group. As well, the safety and efficacy of a single-dose regimen of levonorgestrel (1.5 mg) compared to a two-dose regimen (0.75 mg taken 12 or 24 hours apart) and of single-dose mifepristone (10 mg) for EC, cannot be overemphasised. Earlier treatment is preferable, although these methods can be used effectively for up to 5 days after intercourse. Thus, EC should ideally be taken as soon as possible. As mentioned in your editorial, the IUD still remains a highly effective method of EC up to 7 days after unprotected intercourse. Unfortunately, persisting myths about IUDs continue to limit their prescription for young, nulliparous women, despite the fact that this population group comprises a large proportion of those who seek EC.

If the overall effectiveness of EC is related to elapsed time after unprotected intercourse, it would make sense to provide it to patients in a timely fashion. This would include access to an EC provider (with or without prescription) at an affordable cost. Your editorial discussed the success of walk-in clinics with over 3000 people receiving EC. While the absolute cost was not mentioned, it was reassuring to note that several clinics provided EC free of charge without an age limit.

About 10% of the adolescent population become pregnant in North America each year and 95% of these pregnancies are unwanted.<sup>3</sup> A

Canadian study reviewed the success of a pilot programme for providing EC via a pharmacy without a prescription.<sup>4</sup> Almost 7000 prescriptions were obtained and 21% of women stated that if they had not obtained EC in this manner, they would not have obtained it elsewhere. The Canadian health minister recently introduced a bill to remove EC from its current 'prescription-requiring status' making it available 'over the counter', thereby further removing barriers to access by women of all ages. According to the UK guidelines, the cost of licensed EC products available at pharmacies range from £5.50 with a prescription to £24.00 for an over-the-counter (OTC) product. To make matters worse, OTC products are limited to patients over 16 years of age. Imposing these restrictions on EC severely limits access to the products in the population least likely to see a physician and most likely to benefit from their use.

The medical eligibility criteria for EC are quite broad. According to the WHO guidelines<sup>5,6</sup> there are no absolute contraindications to EC use, which supports the safety of providing EC as an OTC product. If a prescription is required, advanced issue of a prescription for EC does not cause an increase in the use of EC (i.e. patients do not abuse EC as a form of regular contraception). Indeed, they are more likely to use EC when needed and are also more likely to use standard contraception properly.<sup>7</sup>

Hormonal EC needs to be made accessible to all women, but especially to adolescents. This is most likely to occur in an environment where they can access EC at a convenient time, in a convenient location, at a convenient price (preferably free of charge). Only then might we start to see the financial and social benefits of primary prevention of unwanted pregnancies in this age group.

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#### References

- 1 Webb AMC. Emergency contraception: latest changes. *J Fam Plann Reprod Health Care* 2004; **30**: 8-9.
- 2 Task Force on Postovulatory Methods of Fertility Regulation. Randomised controlled trial of levonorgestrel versus the Yuzpe regimen of combined oral contraceptives for emergency contraception. *Lancet* 1998; **352**: 428-433.
- 3 Elfenbein DS, Felice ME. Adolescent pregnancy. *Pediatr Clin North Am* 2003; **50**: 781-800.
- 4 Dunn S, Brown TE, Cohen MM, et al. Pharmacy provision of emergency contraception: the Ontario emergency contraception pilot project. *J Obstet Gynaecol Can* 2003; **25**: 923-930.
- 5 World Health Organization (WHO). *Improving Access to Quality Care in Emergency Contraception: Medical Eligibility Criteria for Contraceptive Use (2nd edn)*. WHO/RHR/00.02. Geneva, Switzerland: WHO, 2000.
- 6 World Health Organization (WHO). *Emergency Contraception: A Guide for Service Delivery*. WHO/FRH/FPP/98.19. Geneva, Switzerland: WHO, 1998.
- 7 Glasier A, Baird D. The effects of self-administering emergency contraception. *N Engl J Med* 1998; **339**: 1-4.

#### Reply

Madam

As mentioned in my original article there is only one paper<sup>1</sup> that shows a direct correlation between intercourse treatment interval and effectiveness of emergency hormonal contraception (EHC). Neither the subsequent World Health Organization (WHO) paper in 2002<sup>2</sup> nor another large study<sup>3</sup> have shown this correlation.

The 1998 WHO paper quoted by the correspondent was carried out in women within 72 hours of intercourse and only four women used EHC>72 hours. In the 2002 paper the authors clearly state: "There was no evidence of an interaction between regimens and timing of treatment within 72 hours or after 72 hours. For the three regimens combined, women who were

treated after 72 hours had a higher pregnancy rate than those treated within 72 hours but the difference was not significant". Another study looking at the Yuzpe regimen between 72 and 120 hours<sup>3</sup> also had small numbers and, therefore, wide confidence intervals so it is difficult to know the true efficacy.

The 2002 paper shows that the 1.5 mg levonorgestrel stat dose regimen is as safe and effective as a split dose; it therefore seems logical that the simpler dosing should be the one of choice. I agree that EHC should be ideally used as soon as possible and that this may be best achieved by ensuring that any woman who may, at sometime in her life, be at risk, has some easily available. After all, don't most people have simple painkillers at home and sometimes in their handbags in case they should get a headache? This is despite both aspirin and paracetamol (acetaminophen in North America) having a considerably greater list of contraindications and side effects than levonorgestrel.

My mention of the intrauterine device (IUD) was precisely to remind clinicians that they should not be constrained by myths. Fitting an IUD in a nulliparous woman is a common occurrence in our service and acceptance, as with all methods, is related more to the adequacy of counselling and practical expertise of the fitter than with the parity or age of the woman.

Contraception in the UK is free when on a National Health Service prescription. When bought from a pharmacy without prescription, the cost of EHC is indeed high. I agree that the age restriction has no medical basis. I was delighted to hear that Canadians now have access to EHC without prescription. I hope it is at an affordable price. It was very disappointing that the USA Food and Drug Administration (FDA) did not feel able to make an equally enlightened decision despite the advice they received.

EHC is safe and should be broadly and affordably available to all who need it. However it is not the answer to unwanted pregnancies<sup>5</sup> and must be part of a much wider effort to increase knowledge, accessibility, affordability and usability of all methods of contraception and prevention against sexually transmitted infections.

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#### References

- 1 Task Force on Postovulatory Methods of Fertility Regulation. Randomised controlled trial of levonorgestrel versus the Yuzpe regimen of combined oral contraceptives for emergency contraception. *Lancet* 1998; **352**: 428-433.
- 2 von Hertzen H, Piaggio G, Ding J, et al. Low dose mifepristone and two regimens of levonorgestrel for emergency contraception: a WHO multicentre randomised trial. *Lancet* 2002; **360**: 1803-1810.
- 3 Ellertson C, Webb A, Blanchard K, et al. Modifying the Yuzpe regimen of emergency contraception: a randomized, controlled, multicentre trial. *Obstet Gynecol* 2003; **101**: 1160-1167.
- 4 Ellertson C, Evans M, Ferden S, et al. Extending the time limit for starting Yuzpe regimen emergency contraception to 120 hours. *Obstet Gynecol* 2003; **101**: 1168-1171.
- 5 Glasier A, Fairhurst K, Wyke S, et al. Advance provision of emergency contraception does not reduce abortion rates. *Contraception* 2004; **69**: 361-366.

#### Service standards: chaperones and record keeping

Madam

We are grateful for the responses from McVicker, Murray and Robinson<sup>1,2</sup> but without wishing to over-prolong this debate we would like to clarify the problems a little more.

(1) If the offer of a chaperone is essential for doctors, guidance is also needed for nurses. The Association for Genito-Urinary Medicine (AGUM) guidelines for intimate examinations in genitourinary clinics<sup>3</sup> point out that there is a problem, both with the nature of sexual health

work (which makes it difficult for relatives and friends to chaperone) and with nurses performing examinations, but they do not offer any immediate solution. With the increasing role of nurses in reproductive health and general practice<sup>4</sup> this is a real issue. Will we all have to be able to provide two nurses to do every smear test, and will they not be seen as supporting each other rather than the patient?

We have both noticed an increasing reluctance among general practitioners (GPs) to perform intimate examinations, and a tendency to send women to our services for them. GPs may lose very little under the new contract if they give up cytology and contraception<sup>5</sup> but the burden will fall on community clinics. If extra nurses therefore have to be employed as chaperones they must be specifically funded, otherwise our services will increasingly have to limit the number of clients they can see per session so that nurses are freed up to do this very unrewarding task. This may ensure that we are protected against false accusations of improper conduct during a routine intrauterine device check, but that the distraught teenager needing urgent advice who turns up at the last minute is turned away. Is this what we really want?

Unless professional bodies and the General Medical Council (GMC) support clinicians who are working under pressure, the result will be a decrease in the availability of clinical services, with the burden falling chiefly on the most vulnerable patients.

(2) We are grateful for guidance on record keeping, but are concerned that 'good record keeping' is often confused with 'extensive record keeping'. No-one would support careless, inaccurate records, and there are situations where notes written for medico-legal purposes are obviously needed, but densely written, defensive notes can be dangerous. First, because they may mean the clinician is not listening to the patient but is concentrating on writing. Second, because they make it difficult for the next clinician to spot the clinically important points therein. Red ink to highlight important points is not allowed as it does not photocopy well, and stickers and stamps can still be surrounded by lines or even pages of writing.

We call on the Faculty of Family Planning and Reproductive Health Care to review the implementation of the GMC, Royal College of Obstetricians and Gynaecologists (RCOG) and AGUM guidance on intimate examinations in community and primary care situations. We also ask for explicit support in future service standards for clear, concise notes that are written out of a desire to communicate well rather than out of fear of lawyers.

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#### References

- 1 Murray L, McVicker J. Service standards for sexual health (Letter). *J Fam Plann Reprod Health Care* 2004; **30**(3): 196.
- 2 Robinson C. Service standards for sexual health (Letter). *J Fam Plann Reprod Health Care* 2004; **30**(3): 196.
- 3 Rogstad, K. *Intimate Examinations in Genitourinary Medicine Clinics*. [http://www.agum.org.uk/filingcab/intimate\\_examinations](http://www.agum.org.uk/filingcab/intimate_examinations).
- 4 Campbell P. The role of nurses in sexual and reproductive health. *J Fam Plann Reprod Health Care* 2004; **30**(3): 169-170.
- 5 Gafos M. The new General Medical Services (GMS) contract and the National Strategy for Sexual Health and HIV in England. *J Fam Plann Reprod Health Care* 2004; **30**(3): 147-149.

#### Editor's Note

This letter has been forwarded to the Chair of the Clinical Standards Committee.