

News Roundup/Journal Club

contains updated content and illustrations and an expanded description of ligation and excision with fascial interposition, a method that has been shown to significantly improve the procedure's effectiveness.

Founded in 1943, EngenderHealth is a non-profit organisation that has been working internationally for more than 30 years to support and strengthen reproductive health services for women and men worldwide. Since its inception, its work has improved the health of more than 100 million individuals in 90 countries. Further information about the agency and copies of the guides are available at <http://www.EngenderHealth.org>.

New prescribing information for the desogestrel oral contraceptive

Following new evidence, the prescribing information for the desogestrel oral contraceptive (Cerazette®) has been changed. One of the disadvantages of progestogen-only pills (POPs) compared with combined oral contraceptives (COCs) has been the need to take it at the same time each day, with only 3 hours' 'forgetting time'. Now a study has confirmed that forgetting this desogestrel pill for 12 hours is not related to ovulation.¹ In a study of women with confirmed previous ovulation, 103 women took Cerazette for 56 days and 12 hours late on three scheduled occasions. Only one ovulated (measured by alternate day progesterone P levels). That episode was not temporally related to late taking of the pill. The minimum time to post-treatment ovulation was 7 days with an average of 17.2 days from the last tablet taken to ovulation. So now you can give people taking the desogestrel POP the same information as you have done for COCs – if the missed pill is remembered and taken within 12 hours, no additional contraceptive precautions are required.

Reference
¹ Korver T, Klipping C, Heger-Mahn I, et al. Maintenance of consistent ovulation inhibition with the 75 mcg desogestrel-only contraceptive pill Cerazette® after scheduled 12-hour delays in tablet-intake. Study reported at the European Society of Contraception, Edinburgh, UK, July 2004.

Anaphylactic shock and DMPA

Depot medroxyprogesterone acetate (DMPA) is thought to be very safe. Occasionally serious and potentially life-threatening adverse effects can occur. This case study reports a 40-year-old

woman who went into anaphylactic shock after receiving 150 mg DMPA intramuscularly.¹ She was not taking any other medication, and there was no history of allergy to food or cosmetics. She responded fully to immediate resuscitation. A repeat episode occurred when she received another dose 12 weeks later (I would not have risked it!). Life-threatening adverse effects can occur with administration of any medication and clinicians should be prepared for such an eventuality.

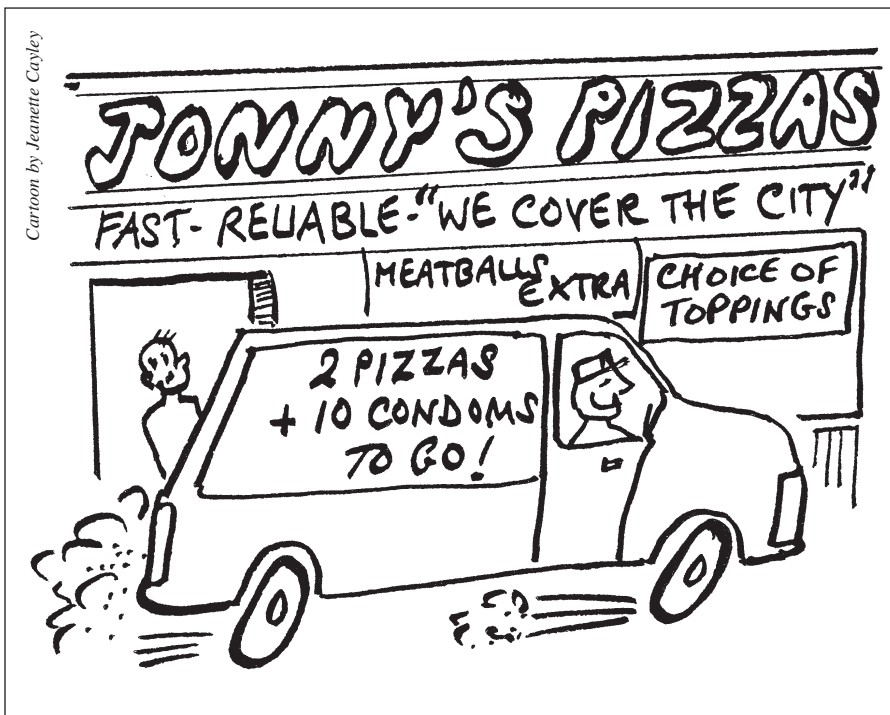
Reference
¹ Selo-Ojeme DO, Tillisi A, Welch CC. Anaphylaxis from medroxyprogesterone acetate. *Obstet Gynecol* 2004; **103**(5 Pt 2): 1045–1046.

Condom express

The Swedish Organisation for Sexual Education has launched a service to provide emergency condoms to those in desperate need! Using the name Cho-San Express, the organisation will

have four cars loaded with condoms patrolling the streets of the capital, Stockholm, along with a pair of vehicles each in Goteborg and Malmoe, Sweden's second and third largest cities, respectively. The express will deliver a pack of 10 condoms for slightly less than is charged at a state-owned pharmacy. The organisation hopes to 'reach young people with a humorous twinkle in their eye'. They hope that the contraceptive will be seen as a fun sex accessory and not just as a way to protect against STIs. The initiative follows similar increases in STIs to those seen in the UK. Further information is available at http://ippfnet.ippf.org/pub/IPPF_News/News_De tails.asp?ID=3503.

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



JOURNAL CLUB

Reproductive effects of male psychologic stress. Henrik N, Bonde J, Henriksen T, et al. *Epidemiology* 2004; **15**: 21–27

This interesting study looks at the relationship between stress and infertility, and whether higher stress levels are related to low sperm counts. A total of 430 Danish couples who were trying to become pregnant for the first time were followed prospectively. Initially the clients filled out a general health questionnaire and had a blood sample taken for luteinising hormone, follicle-stimulating hormone, inhibin B, testosterone or oestradiol. The men also collected a semen sample at the beginning and each month during the 6-month follow-up. A shorter version of the general health questionnaire was completed each month following. The pregnancy rate was 14% in those with the highest scores for stress and 18% for those with the lowest scores. The odds for pregnancy per cycle were reduced significantly as the stress score increased. However, the median values of semen volume, sperm concentration and motility showed no statistical difference in the various ranges of the general health questionnaire scores. Neither was there much effect on the hormone levels. This would seem to suggest that day-to-day stress is not

a strong determinant of semen quality, but that stress may have an effect on fecundity.

Reviewed by **Laura Patterson, MRCP, DFFP** GP Non-Principal and Associate Specialist in Family Planning, Swindon, UK

How is the high vaginal swab used to diagnose vaginal discharge in primary care and how do GPs' expectations of the test match the tests performed by their microbiology services? Noble H, Estcourt C, Ison C, et al. *Sex Trans Infect* 2004; **80**: 204–206

This paper cannot be regarded as a reliable guide to opinion as the researchers only obtained a response from 26% of the 2146 general practitioners (GPs) and 22 laboratories in the North Thames area. A postal questionnaire asked GPs how they would manage a young woman with vaginal discharge and what information they would like on the laboratory report. The questionnaire for the laboratories asked how they processed and reported on a high vaginal swab (HVS). Most of the GPs who replied (78%) said that they would have liked to have a diagnosis suggested, and 74% would have liked the laboratory to suggest treatment. The majority of the 14 laboratories that replied did not meet their wishes. The diagnosis was given in 43% and a treatment advised in only 14% of cases. Perhaps the GPs and the laboratories should talk to each

other to determine each other's needs? This paper might make other areas look at what GPs and laboratories expect from each other and, if there is a similar mismatch, find ways of rectifying it.

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

Breast cancer and abortion: collaborative reanalysis of data from 53 epidemiological studies, including 83 000 women with breast cancer from 16 countries. Collaborative Group on Hormonal Factors in Breast Cancer. *Lancet* 2004; **363**: 1007–1016

Pregnancies that result in a birth are known to reduce a woman's risk of breast cancer, but the effect of pregnancies that end as an abortion is less clear. Evidence from retrospective studies has been difficult to interpret because women have a tendency to under-report both spontaneous and, particularly, induced abortion, whereas women diagnosed with breast cancer may be more likely to disclose this information.

The authors of this paper reviewed worldwide evidence and analysed the results from prospective and retrospective studies separately. Among women with a prospective record of having had one or more induced

abortions, the relative risk of breast cancer was 0.93 (95% CI 0.89–0.96), compared with women who had never had an induced abortion. The corresponding relative risk for spontaneous abortion was 0.98 (95% CI 0.92–1.04).

In contrast to the findings of many retrospective studies, the prospective data suggest that induced or spontaneous abortions do not increase a woman's risk of breast cancer.

Reviewed by **Louise Melvin**, MRCOG
Clinical Research Fellow, Royal Infirmary of Edinburgh, Edinburgh, UK

Effects of conjugated equine estrogen in postmenopausal women with hysterectomy. The Women's Health Initiative Randomised Controlled Trial. *JAMA* 2004; **291**: 1701–1712

This study was one of two parallel, randomised, double-blind, placebo-controlled trials designed to test the effects of this type of hormone replacement therapy (HRT) on chronic disease. The National Heart, Lung and Blood Institute in the USA set the study up 13 years ago. The oestrogen plus progestogen arm of the trial was halted in July 2002 due to increased risk of coronary heart disease, thromboembolic disease and breast cancer. This arm of the trial compared use of oestrogen only HRT (conjugated equine oestrogen) with placebo in nearly 11 000 women aged 50–79 years. The study was stopped a year before its scheduled conclusion, even though no predefined boundaries had been crossed. There was also a high degree of non-compliance: 50% by the seventh year. The study provides us with some important information. The treatment group had a 39% increased risk of stroke compared to the non-treatment group (44 vs 32 per 10 000

person-years). Contributing factors may have been the small but persistent increase in blood pressure and the known effect of oestrogen on increasing the risk of thrombosis. There was a reduction in low-density lipoproteins (LDLs) and an increase in high-density lipoproteins (HDLs) but no impact on coronary heart disease incidence. Oestrogen reduced the risk of fractures by 30% to 39% (11 vs 17 per 10 000 person-years) in the treatment group. They reported a lower rate of breast cancer in the treatment group compared to placebo. This particular result is contrary to the oestrogen plus progestogen arm of the Women's Health Initiative (WHI) trial and clearly needs further investigation. The small numbers may have confounded the results. Two components of the WHI on the effects of a low-fat eating pattern, and the effects of calcium and vitamin D supplements are still awaiting publication. For the present time, this study contributes further weight to the advice that HRT should be used for short-term relief of vasomotor symptoms only.

Reviewed by **Laura Patterson**, MRCGP, DFFP
GP Non-Principal and Associate Specialist in Family Planning, Swindon, UK

Advanced provision of emergency contraception does not reduce abortion rates. Glasier A, Fairhurst K, Wyke S, et al. *Contraception* 2004; **69**: 361–366

This is a community intervention study designed to determine whether offering advanced supplies of emergency contraception (EC) to large numbers of women influenced the abortion rates. In one area of Scotland women between 16 and 29 years were targeted through health services to

be allowed to take home five courses of EC to keep for when needed. There were 85 000 women in the target age group of whom 17 800 took a supply of EC home. Some 45% of this group took at least one course of the EC provided. The authors state that they have low abortion numbers in the intervention area (<2000 per year of the target group) and also reported that there is a high uptake of contraception in the area but numbers are not given. The results of the intervention did not reduce the abortion rate when compared with other areas of Scotland with no intervention.

In their discussion the authors did not emphasise that the EC used was Schering PC4 which is now not available. Levonelle® is now prescribed as it has been shown to be more effective but by how much is debatable. If the area targeted had a high uptake of contraception use then women probably were not aware of their pregnancy risks when using other methods so did not use EC when necessary. This study shows that no matter what we do as clinicians, we cannot predict what contraceptive users will do and how competently they can recognise when they are at risk of pregnancy.

The study leaves concerns that sexually active young people are given messages that EC is available if they have pregnancy risk but this study may indicate that by making EC readily available this still will not impact on the abortion figures. Abortion figures will only reduce when the sexually active population are willing to use more effective long-term methods of contraception where EC is rarely needed.

Reviewed by **Judy Murty**, DRCOG, MFFP
SCMO, Contraceptive and Sexual Health Services, Leeds, UK

BOOK REVIEWS

The X in Sex: How the X Chromosome Controls Our Lives. D Bainbridge. Cambridge, MA: Harvard University Press, 2003. ISBN: 0 674 01028 0. Price: £12.49. Pages: 181 (hardback)

This highly readable book tells the story of the X chromosome from Aristotle's musings on gender differences right through to a modern understanding of the genetics of the X chromosome. The author's engaging style makes modern genetics accessible both to the complete layperson and to those of us for whom preclinical genetics are a hazy memory. Bainbridge is a lecturer on comparative anatomy and physiology at the Royal Veterinary College in London and uses his broad knowledge of the animal world to set human sex determination in a fascinating wider context. Who would have thought that many species could do away with the Y chromosome altogether, or that the male kangaroo uses his redundant pouch as a scrotum?

In a chapter entitled 'The Duke of Kent's Testicles', Bainbridge describes the unfortunate spread of haemophilia through 19th century European Royal families to illustrate the inheritance of sex-linked disorders. From a disastrous random mutation in a sperm in one of the Duke's testicles to the Russian Revolution, the history is irreverent but the genetic implications are well illustrated.

The final chapter covers intriguing aspects of

human sex determination: what makes men into men and women into women, in both the genetic and the broader senses. This chapter explains why identical twins are more often female than male and also why female twins are never quite so identical as male twins. There are also genetic theories to explain why women are more prone to autoimmune disease. Best of all is the revelation that little girls express a gene for good behaviour – and little boys do not!

This slim book is a good read, amusing yet informative and authoritative.

Reviewed by **Kate Weaver**, MB ChB, MFFP
Staff Grade Doctor in Reproductive Health Care, Edinburgh, UK

Sexual Pharmacology: Fast Facts. Robert Taylor Segraves and Richard Balon. New York, NY: W W Norton & Company, 2003. ISBN: 0 393 70354 1. Price: £24.68. Pages: 311 (paperback)

This American book has a catchy title that completely describes what you are getting – or does it? It seems obvious to point out that the book is very pharmacological, but perhaps the subject cannot be fitted quite so completely into pharmacological categories. These 'facts' seem to have been over-interpreted when presented to 'practising physicians'. The lists of references included a wide range of animal studies (mice, cats, rats, hamsters, stallions, male mosquito fish and striped bass). I was concerned as to how much of this could really be evidence of sexual function in the human species.

The book is divided into two halves. The first deals with the effects of drugs on the causation of sexual problems and the second addresses drug treatment for sexual problems. The introduction to the treatment of premature ejaculation says: 'None of the mentioned agents has been approved by the FDA for the treatment of PE'. It seems unusual to devote a whole chapter on treatment to unlicensed drugs.

Although passing reference is made to the 'psychosocial context' it would be easy reading this book to feel that the answers to sexual problems lie only in pharmacology. The authors state that: 'Many men have ... unrealistic expectations of their sexual performance'. There was no suggestion that this too needs addressing.

The authors ask even more of us in the consultation. They state: 'It is critical to obtain a baseline measure of sexual function prior to starting a new pharmacological treatment'. This seems an unachievable goal. We know that doctors are not yet very good at talking with their patients about sex. Furthermore, the time constraints within which we all work mean that this issue will not always have sufficient priority to merit a share of the consultation.

Having felt cause to argue in particular with the way things are said in this book, I do think it has some use in presenting pharmacological information about sexual function. Perhaps that is after all what it intended to do.

Reviewed by **Alex Connan**, MRCGP, MIPM
General Practitioner and Family Planning Doctor, Edinburgh, UK

WEBSITE REVIEWS

Understanding laboratory tests

The Association of Clinical Biochemists has

launched this website to help patients understand about laboratory testing. I suspect (see the review about high vaginal swab testing and reporting) that many doctors might also find it helpful. The home page gives some news items, together with a search box and some drop-down menus. The menus are headed Tests, Conditions and Diseases

and Screening, so that information about individual tests or conditions can be located. On the left are links to more general information such as how to interpret the terms used in tests (like reference ranges) and tours of what happens to samples when they reach the laboratory. There is a feedback page and the site is peer-reviewed,