

## LETTERS

resuming pill taking and/or starting the next pack without a break) and to avoid risk of pregnancy (by advising condoms/abstinence for 7 days). EC is not indicated when this advice is followed.

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- 1 World Health Organization (WHO). *Selected Practice Recommendations for Contraceptive Use* (2nd edn). Geneva, Switzerland: WHO, 2004. [http://www.who.int/reproductive-health/publications/rhr\\_02\\_7/index.htm](http://www.who.int/reproductive-health/publications/rhr_02_7/index.htm).
- 2 Faculty of Family Planning and Reproductive Health Care Clinical Effectiveness Unit. Faculty Statement from the CEU on a New Publication: WHO *Selected Practice Recommendations for Contraceptive Use* Update. Missed pills: new recommendations. *J Fam Plann Reprod Health Care* 2005; **32**: 153-155.

**When is a pill missed?**

The latest WHO and CEU guidance for the action to be taken when oral contraceptive pills are missed<sup>1,2</sup> is much more forgiving than the recommendations we have been used to following in the UK for many years. In particular, the guidance states that women have to miss three or more 30 µg pills before needing to take additional contraceptive precautions. Much depends on how we interpret these words. If a pill is only considered to be 'missed' after 24 hours when it is time for the next pill to be taken, then a woman would be following the guidance correctly if she started a new packet of pills after very nearly a 10-day pill-free interval and took no additional precautions at all. Although this may be sufficient for the majority of women, there will undoubtedly be some who ovulate on such a regimen,<sup>2</sup> particularly if they forget more pills later in the packet or during the next month. It seems more sensible to interpret the WHO guidance in the context that if a pill is taken only 1 hour late it has been missed. At least this is more consistent with what we have told our patients in the past, even if the words are different.

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- 3 Killick SR. Ovarian follicles during oral contraceptive cycles: their potential for ovulation. *Fertil Steril* 1989; **52**: 580-582.

**Reply**

The new recommendations on missed pills published in April 2005<sup>1</sup> are based on findings of a WHO Expert Working Group with UK representation.<sup>2</sup> These new recommendations are not very different from previous recommendations from the CEU,<sup>3</sup> the FFPRHC<sup>4</sup> and the WHO<sup>5</sup> (where missed pill rules were applied if starting a pill packet two or more days late or if any two to four pills were missed in Week 1). There was inconsistency, however, in how missed pill recommendations were being used in the UK. It is hoped that with the publication of new recommendations and fpa information leaflets that guidance and advice given to women will be harmonised throughout the UK.

The CEU does not now use the term 'late' pills as it has done in previous guidance. The CEU considers a pill to be 'missed' when one is completely omitted (more than 48 hours have elapsed since taking the last pill). The CEU

recommend that action need only be taken when three pills are missed (or two if using a 20 µg pill) in any week of pill taking. Seven pills are omitted every month in the pill-free interval (PFI) without concerns about loss of efficacy. Pills missed in Week 1 may extend the PFI to 10 days. The CEU acknowledge there may be inter-individual variation in risk of ovulation by extending the PFI but available data is reassuring even with a 10-day PFI.

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- 3 Faculty of Family Planning and Reproductive Health Care Clinical Effectiveness Unit. FFPRHC Guidance (October 2003). First prescription of combined oral contraception. *J Fam Plann Reprod Health Care* 2003; **29**(4): 209-223.
- 4 Faculty of Family Planning and Reproductive Health Care (FFPRHC). *UK Selected Practice Recommendations for Contraceptive Use*. London, UK: FFPRHC, 2002. <http://www.ffprhc.org.uk>.
- 5 World Health Organization (WHO). *Selected Practice Recommendations for Contraceptive Use* (1st edn). Geneva, Switzerland: WHO, 2002.

**Editor's Note**

This debate on missed pills has also found its way into *The Lancet*. Interested readers should refer to: Mansour D, Fraser IS. Missed contraceptive pills and the critical pill-free interval. *Lancet* 2005; **365**: 1670-1671.

**Emergency contraception for women aged over 40 years**

The Faculty Guidance document from the CEU on 'Contraception for women aged over 40 years'<sup>1</sup> does provide a wealth of evidence-based practical guidelines on the subject.

I am surprised that in such a voluminous publication, except for a passing comment merely citing two references, no mention is made about emergency contraception (EC), which may provide an additional effective contraceptive option.

The Guidance document spells out that barrier methods are currently used by one-third of the older women using contraception in the UK.<sup>2</sup> It would have been appropriate to emphasise that women using barrier methods should be adequately informed and counselled about the methods of EC in case of inability to use or failure during use of barrier contraception.

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- 1 Faculty of Family Planning and Reproductive Health Care Clinical Effectiveness Unit. FFPRHC Guidance (January 2005). Contraception for women aged over 40 years. *J Fam Plann Reprod Health Care* 2005; **31**: 51-64.
- 2 Dawe R, Rainford L. *Contraception and Sexual Health 2003* (updated version). London, UK: Office for National Statistics, 2004. <http://www.statistics.gov.uk>.

**Reply**

Thank you for the opportunity to re-emphasise the safe and effective use of emergency contraception (EC) when contraceptive methods fail or unprotected sex has occurred.

In the CEU Guidance on 'Contraception for women aged over 40 years'<sup>1</sup> our objective was to provide overall guidance on contraceptive choices for women in this age group. We also aimed to highlight and provide information on health concerns specific to this age group of women. Much information was provided on combined

hormonal contraception in relation to cardiovascular disease, cancer, bone health and bleeding due to the concerns of women and clinicians on the use of these methods by women over the age of 40 years. Sterilisation was particularly emphasised as this is a commonly used method for women and couples aged over 40 years.

We recognise that in the UK the male condom is a common method of contraception chosen by couples in this age group. However, we perhaps failed to emphasise the importance of informing women about the use of EC should barrier methods fail. The CEU found no evidence to suggest that women aged over 40 years should be prescribed progestogen-only emergency contraception (POEC) differently from women aged under 40 years. For women of all ages, EC (both POEC and the copper intrauterine device) are effective options when there has been unprotected intercourse or potential contraceptive failure. The CEU advise that when EC is indicated, women should be counselled and offered both options even if presenting within 72 hours.<sup>2</sup>

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- 2 Faculty of Family Planning and Reproductive Health Care Clinical Effectiveness Unit. FFPRHC Guidance (April 2003). Emergency contraception. *J Fam Plann Reprod Health Care* 2003; **29**(2): 9-16.

**Chlamydia screening in general practice: a missed opportunity?**

The second phase of the National Chlamydia Screening Programme (NCSP) is currently underway in a quarter of primary care trusts in England, covering settings such as family planning, antenatal, colposcopy and termination of pregnancy services as well as general practice.<sup>1</sup> There is not much literature that relates to implementing chlamydia screening in general practice so the paper by Harris<sup>2</sup> in the April 2005 issue of the Journal is very timely. However, I feel he hasn't considered the full potential of 'opportunistic' screening to make the screening more effective.

Harris observed there are opportunities to discuss chlamydia screening in general practice. Chlamydia screening was offered to women aged between 16 and 25 years attending for smears or consulting about contraception, and men aged between 16 and 34 years at a new patient health check appointment. I have several concerns with this approach.

First, the cervical cytology screening schedule in the UK no longer invites women under the age of 25 years. In the paper, three out of the five positive cases were screened during cervical cytology; hence relying on this consultation would potentially miss the group of young women in whom the infection is most prevalent.

Second, although it was good practice to offer chlamydia screening as part of sexual health promotion, offering screening to those who attend only for cytology and contraception would worsen health inequalities by denying screening to those who are least educated and informed to use preventative services and consequently increasing the risk of infection.

My third concern is the men. The author rightly pointed out that men have responsibility for their sexual health but the only opportunity to screen them appeared to be at the new patient check. If men are traditionally perceived to be low users of health services, then every opportunity must be used to invite them to be screened.

In addition, I fail to see why only clinicians should recruit the target groups opportunistically.