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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When is a pill missed?

The latest WHO and CEU guidance for the action to be taken when oral contraceptive pills are missed[1,2] 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,[2] 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[1] are based on findings of a WHO Expert Working Group with UK representation.[2] These new recommendations are not very different from previous recommendations from the CEU,[3] the FFPRHC[4] and the WHO[5] (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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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'[1] 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.[2] 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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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'[1] 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.[2]

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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.[1] There is not much literature that relates to implementing chlamydia screening in general practice so the paper by Harris[2] 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.

In the pilot screening programmes, reception staff recruited most of the screening subjects in general practice and family planning clinics. Making use of other members of the primary health care team would significantly reduce the burden on clinical staff and therefore the cost of a population-wide screening programme.

Finally, the author attempted to calculate the cost per case detected and treated. A formal economic evaluation, which includes administrative and clinical time, would be more helpful, but is beyond the scope of his paper. Some of these issues are already addressed in the economic evaluation arm of Chlamydia Screening Studies (CLaSS).[3]

Our practice started testing for chlamydia and other sexually transmitted infections (STIs) in the risk groups since June 2004 as part of National Enhanced Service (NES) for More Specialised Sexual Health Services. We put up posters and information in the waiting room to encourage testing; this enabled patients to feel empowered to initiate STI screening. Clinicians also felt less embarrassed about bringing up the subject of screening because patients understood this is what we offer routinely. We have identified and treated 14 cases of chlamydia to date, in both men and women.

Apart from making use of non-clinical staff, we need information campaigns to raise awareness and normalise the screening process. Opportunistic strategies will only work if individuals feel empowered to request screening; an information campaign should therefore not only focus on health professionals but on patients too.

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2 Harris D. Implementation of chlamydia screening in a general practice setting: a 6-month pilot study. *J Fam Plann Reprod Health Care* 2005; **31**: 109–112.
3 http://www.chlamydia.ac.uk [Accessed 24 April 2005].

Reply

I would like to thank Dr Ma for his helpful comments.

The study was undertaken in late 2003 when cervical cytology screening offered an ideal opportunity for us to contact women in our cohort. We do not rely on any single method of contracting patients in the at risk group.

Screening for chlamydia is not denied to any of our patients. Posters about chlamydia screening are displayed in patient waiting areas and toilets. The posters have been modified to hold an information leaflet on chlamydia and a request slip to take to the reception area to ask for a urine pot for chlamydia testing.

In an ideal world with unlimited consultation time it would be great to offer everybody screening for everything. However, as I pointed out in my article, I recognised that GPs are under increasing pressure to offer yet more health promotion advice in a routine consultation; it was for this reason that screening was restricted in the first instance. The idea was to demonstrate to GPs that they could offer screening during a normal consultation rather have to set up a new service to do this.

Practice nurses, health care assistants and GPs were involved in offering opportunistic screening during the pilot study described in my article. Information leaflets and request slips for a chlamydial urine test are freely available in the practice and these can be taken to reception staff who are happy to provide a urine test pot for screening. We felt it was important to discuss the pros and cons for screening and what the patient might do if the result was positive. And it was for this reason we chose not to involve our reception staff directly in the offer of screening.

With regard to the economic evaluation, as I clearly stated in my article this did not include administrative or clinical time, which I agree would have been more helpful; however, this was beyond the scope of the article.

Like Dr Ma we have empowered our patients to make decisions about their screening needs. I wish Dr Ma every success with the article he has submitted to the Journal on chlamydia screening in general practice.

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Cerazette for premenstrual tension

It was interesting to read Mr Ali Kubba's letter published in the October 2004 issue of your Journal on the above subject.[1]

I have prescribed Cerazette® for a small cohort of patients (eight patients) in my PMS/Menopause Clinic, who presented with both psychological and physical symptoms within the last year. In 6/8 patients there was a marked improvement in the psychological symptoms and moderate improvement was seen in physical symptoms within 3 months of starting the treatment.

One patient did not show any improvement in her physical or psychological symptoms and since went on fluoxetine with marked improvement of her symptoms, and one patient's psychological symptoms got worse to the extent of personality changes and suicidal tendencies and these symptoms completely disappeared on stopping Cerazette.

All these patients were sexually active young women with an age range of 25–45 years. Of the six women who showed an improvement in their symptoms, only three women became amenorrhoeic with this treatment; the other patients, despite an improvement in their symptoms, had irregular cycles.

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Spinal fracture in a young Depo-Provera user

Following the latest alarm[1] on the risks of osteoporosis in Depo-Provera® users, a 22-year-old patient of ours was admitted in January 2005 with a fractured vertebra following low-impact trauma. She had been on Depo-Provera for almost 3 years. She had had irregular menstrual spotting only with no actual bleeding as is common with long-term injectables.

She first attended our clinics at age 15 years with heavy regular cycles, weighing 8 stone and smoking 10 cigarettes per day. The only other possibly relevant point in her medical history was her mother's muscle wasting disease on the left side of her back. She chose the combined pill until changing to Depo-Provera at age 19 years. She now weighs 10 stone 13 pounds, her height is 5'1" and she has a body mass index of 29. She stopped smoking 2 months ago.

The vertebral fracture occurred at home when she was putting on her shoes, lost her balance and fell backwards onto the floor. She is on no medication, has never taken corticosteroids, has had no symptoms of oestrogen lack, and goes to the gym three times weekly.

Eventually she came to the top of the bone scan waiting list and her bone mineral density (BMD) was reported as: "Hip BMD = 1.054 g/cm^2. % expected for age: 112%. Lumbar spine BMD = 0.980. % expected for age: 95%. The result is normal".

The hospital immediately took her off Depo-Provera when the fracture occurred. Does this case illustrate that an association does not equate with causation, at least for this individual?

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Stop 'QOFing' and moaning; start lobbying!

Following on from my last rant,[1] I feel compelled to write again to represent another view from primary care. Dr Bugerem dismisses the incentive scheme operating in general practice under the new contract that is the Quality and Outcomes Framework (QOF), and notes many of these incentives relate to chronic disease management but not sexual health.[2] I do not subscribe to the comparison of QOF to 'loyalty points'. For a start, you *earn* money with QoF, whereas you have to *spend* money to get the latter!

The strength of the QOF is it rewards practices for achieving prescribed outcomes such as target blood pressures and cholesterol levels, not merely the process of intervention such as measuring blood pressure or cholesterol. The fact that many GPs are exceeding their aspirations on QOF targets is a victory for public health and chronic diseases management.

One thing I do agree with Dr Bugerem is the lack of incentives for provision of sexual health care; this is an issue that the Royal College of General Practitioner's Sex, Drugs and HIV Task Group have been working hard to raise with the GP contract negotiators. Separating sexual health from the core contract to an enhanced service only discourages GPs to offer even the most basic of sexual health care and promotion such as contraception. Merely having policies on preconceptual advice and emergency contraception is not adequate to achieve sexual health outcomes aspired to in the National Strategy for Sexual Health and HIV.[3] Under the old contract, any contraception activity enabled us to claim the contraception fee, which was worth about £17 per patient per year; QOF points relating to contraception are only worth £240 for an average practice of 5000 patients in the 2005/2006 financial year.

Sexual health promotion such as contraception advice, screening for sexually transmitted infections and use of long-acting reversible contraceptives are effective in reducing sexual ill health and unwanted pregnancies. GPs with an interest in sexual health should be joining forces to lobby the GP contract negotiators; sexual health work should be recognised in the core contract and QOF.

We should all stop moaning and start lobbying!

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