Implanon® use in overweight clients

In reference to the letters from Drs Barber and Waters[1] and Dr Matiluko[2] published in the January 2008 issue of the Journal on Implanon® failure and antiretroviral therapy, we were dismayed to see obsolete advice on the management of overweight clients discussed.

The letter from Tristan Barber[1] states that: "earlier replacement of Implanon at 2 years is consistent with current advice". He quotes Member Enquiry #1072. We have read this response and the Clinical Effectiveness Unit (CEU) replied that *although the summary of Product Characteristics* suggests considering the earlier replacement of Implanon in heavier women, *the FFPRHC Guidance is that women weighing over 70 kg should not be treated any differently to other women*.[3] Likewise Member Enquiry #1037[4] also states that weight does not have an effect on the efficacy of Implanon.

Dr Matiluko in his reply[2] suggests that women resuming bleeding after a period of amenorrhoea on Implanon should seek advice about earlier replacement. The CEU recommends following the UKMEC *Selected Practice Recommendations for Contraceptive Use*, namely that women developing bleeding should be investigated if clinically indicated and that the serum concentrations of Implanon remain sufficient to inhibit ovulation throughout the 3 years and a return to bleeding does not demonstrate a return to fertility.[5]

It would be a shame if women over 70 kg were subject to an unnecessary change of Implanon at 2 years because of these letters, and it will also impact on an already overstretched drug budget.

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3 Faculty of Family Planning and Reproductive Health Care Clinical Effectiveness Unit. Members Enquiry Response (Enquiry Reference: 1072). www.ffprhc.org.uk/admin/uploads/No1072.pdf [Accessed 4 February 2008].
4 Faculty of Family Planning and Reproductive Health Care Clinical Effectiveness Unit. Members Enquiry Response (Enquiry Reference: 1037). www.ffprhc.org.uk/admin/uploads/No1037.pdf [Accessed 4 February 2008].
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Reply

Whilst we would agree with current advice regarding Implanon® replacement, many clinicians err on the side of caution if regular menses have recurred or bleeding pattern is unacceptable, after appropriate investigation, particularly if the weight is >100 kg, whilst not being concerned at weights of 70–100 kg. The point of our response was to extrapolate this circumstance and use it as a model for women receiving enzyme-inducing or -inhibiting medication as part of combined antiretroviral therapy, who may have presumed reduced contraceptive efficacy. Although firm evidence is awaited and Implanon is not currently recommended in this group, the fact remains that it is an attractive form of contraception for our HIV-infected cohort and we must be able to give best opinion to patients who use this method as to how most safely to proceed. The number of HIV-infected women using this method, to our knowledge, remains low. Depo-Provera® or IUD/IUS plus barrier contraception (condoms) remain more suitable. It was not our intention for this extrapolation to contravene Faculty advice about the use of Implanon in women >70 kg where we agree early replacement may be unnecessary both for the patient and in terms of expenditure.

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Reply

I am writing in response to the letter[1] written by Dr Cogswell and colleagues. I would suggest they read my letter[2] in the January 2008 issue of the Journal carefully. It was not a generic comment about irregular bleeding on Implanon® but rather advice based on the case reported (i.e. the resumption of regular periods in HIV-seropositive patients on antiretrovirals using Implanon for long-term contraception) which should prompt a review with a view to alternative contraceptive cover.

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Risk assessment documentation in COC prescribing

Documentation is important in the ever-expanding defensive medicine culture, particularly when prescribing medication. As a female Foundation 2 Doctor in General Practice, I see many women for routine contraceptive pill checks. I was surprised to find that very few consultations documented a risk assessment when the pill was first prescribed, considering factors that are very clearly outlined in the *British National Formulary* (BNF). In response to this observation I audited the initial consultations of combined oral contraceptive pill (COC) prescribing to review the documentation of a risk assessment in general practice. The audit served to quantify the standard of medical record keeping and act as a reminder of the risk involved in prescribing the COC. As a result, measures have been taken to improve record keeping in this area, and in turn improve clinical care. Consequently I felt it was an interesting and relevant topic for discussion.

Recording a full risk assessment prior to prescribing the COC is difficult within the time constraints of general practice. However, before prescribing a hormonal method of contraception it is the clinician's responsibility to determine and record any contraindications to use in the individual. Clear guidelines exist for prescribing the COC in the *BNF*[1] and World Health Organization Medical Eligibility Criteria (WHOMEC)[2] and in particular, recognise a risk among women with a personal or family history (FH) of venous thromboembolism (VTE).[3]

An audit carried out in a surgery in North Derbyshire to review the documentation of risk during the first issue of the COC demonstrated poor performance in this area. Of the 134 women audited, only 4% of consultations documented specifically 'no FH of VTE' and 14% included a broad statement like 'no contraindications'. The remaining 82% of consultations made no mention of a risk assessment. A negative personal history of VTE was recorded in 1% of consultations and a further 21% made a general comment with reference to past medical history. The BNF parameters of height, weight, body mass index, smoking status and blood pressure were only completed in 24% of consultations and only 3% included all of these five parameters and had a broad statement regarding risk, for example 'no contraindications'. No consultations included a specific statement about VTE risk, personal or within the family, and all of these parameters.

With the increasing emphasis on defensive medicine, documentation needs to be improved to protect the practitioner and demonstrate the patient gave fully informed consent. In cases where clear guidelines exist on prescribing, general practitioners should ensure their computer templates offer relevant prompts for questioning to allow rapid, complete documentation of the consultation. Ultimately it is the responsibility of the prescriber to ensure that risks do not outweigh the benefits and, if in doubt, consider alternatives.

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Author's note
The text of this letter is taken from a poster presentation by the author at the Medical Woman's Federation '90 Years and Beyond' Conference on 2 November 2007 at the Royal College of Obstetricians and Gynaecologists, London, UK.

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LETTERS TO THE EDITOR

Letters to the Editor are welcome and generally should not exceed 600 words or cite more than five references. For comments on material published in the most recent issue of the Journal, correspondence should be received within 4 weeks of dispatch of that Journal to be in time for inclusion in the next issue. When submitting letters correspondents should include their job title, a maximum of two qualifications and their address(es). A statement on competing interests should also be submitted for all letters. Letters may be submitted to the Editor or the Journal Editorial Office (details on page 73).