

Sisters doing it for themselves

I was interested to read the commentary by Anne Szarewski describing how to individually tailor a woman's combined oral contraceptive (COC) regimen to minimise the amount of breakthrough bleeding she has to experience each year.¹ However, in view of the article on repeat abortion (Das *et al.*) in the same issue of the journal, should we not be more concerned in preventing pregnancy in COC users?² Das *et al.* state that 35% of first attenders were using COC and 55% at repeat abortion.

It is not uncommon to see patients who have become pregnant on the COC pill despite taking it without fault, some patients unfortunately on more than one occasion, having been restarted on their original COC following the end of their pregnancy. These failures of the method could be attributed to the individual woman ovulating as a 7-day pill-free interval is too long for her ovaries to remain quiescent. In view of this, a 24/4 regimen should be the norm but the drug companies seem slow to change their products. Several alternative formulations such as 24/4 or continuous-use pill regimens are available in other countries including the USA and Australia, but none are currently available in the UK, although one has been granted a licence here with a launch date awaited.³ This will no doubt come at a price. Surely all the COC manufacturers should provide a product that is more effective? However, I am sure that the need for a further licence to enable a change to a 24/4 formulation for the cheaper generic COCs would make drug companies reluctant. We can never be certain which patients fall pregnant despite full compliance with the COC taking 'rules' – what is certain is that there will be some women whom this affects each year, and they are likely to be young, new pill starters. This seems awfully unfair on them when in this day and age we have the knowledge to prevent these unwanted pregnancies.

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Sisters doing it for themselves

Our sisters may tailor their combined oral contraceptive (COC) use to reduce their frequency of menstrual bleeds; however, as their responsible elder siblings we have a duty to ensure they make an informed lifestyle choice.

The benefits of a reduction in menstrual bleeds and premenstrual symptoms must be weighed against the lack of any data about the long-term safety of the COC taken continuously. All current knowledge about health risks and benefits of COC use is based on long-term studies of women taking the pill for 21 days in each 28-day cycle. We cannot assume the same benefits (or risks) will apply if the COC is taken continuously.

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Reference

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Reply

I agree entirely with Dr Robinson¹ that that long-term health effects of longer-cycle combined oral contraceptive (COC) use have not been formally studied for more than a few years and we should ensure that monitoring continues. However, we should remember that monthly bleeding is in fact not the norm for healthy, reproductive age women. As Thomas *et al.* have pointed out: "in hunter-gatherer times, women had infrequent menstruations because they had closely spaced pregnancies, they breastfed their infants for long intervals (which suppresses ovulation and menstruation), and they died before reaching menopause. Prehistoric women had as few as 50 menstruations per lifetime, whereas the modern woman has approximately 450 bleeding episodes".² In addition, the bleeding that occurs during the pill-free interval is simply due to hormone withdrawal, not to any physiological need. The studies of longer cycle/continuous pill-taking regimens have so far not given any indication that the adverse event or metabolic profile of extended-regimen oral contraceptives differs in any clinically significant manner from traditional 28-day regimens, while having many health benefits.³ Indeed, even a Cochrane Collaboration review in 2005 concluded that "continuous dosing of COCs is a reasonable approach for women without contraindications to COCs".⁴

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Genuine Depo-Provera® failure

After reading the case report of Lucinda Farmer and Elizabeth Patel entitled 'Contraceptive failure of Depo-Provera®: long-acting reversible contraceptive (LARC) methods do fail too' in the January 2009 issue of this Journal¹ we would like to report a case of genuine Depo-Provera failure. Recently, a 23-year-old girl came to our family planning clinic with abdominal pain, breast tenderness, nausea, vomiting and tiredness off and on for 1 week. The patient was fit and healthy, with a body mass index (BMI) of 19, was a light smoker and normotensive.

The patient had used Injection Depo-Provera® from age 15 to 21 years and had been very happy with this method. She started Depo-Provera on 19 November 2008 on the second day of her cycle at her general practitioner's surgery and received the injection in her buttock. She had another injection at the same surgery 12 weeks later on 11 February 2009. She had one episode of bleeding for 3 days, which began on 18 January 2009.

On history and examination she demonstrated symptoms of pregnancy, and bimanual examination showed an anteverted 8-week-sized uterus with no cervical excitation or tenderness. Both adnexa were clear. A pregnancy test was positive and she opted for termination of pregnancy. Her gestation was 9 weeks 4 days by ultrasound scan.

We would like to highlight that failures can

still occur with perfect use of Depo-Provera. Although current Faculty of Sexual and Reproductive Healthcare (FSRH) and National Institute for Health and Clinical Excellence (NICE) guidance mention a low failure rate (i.e. 4 in 1000 over 2 years) for the progestogen-only injectable given in accordance with the licensed use of every 12 weeks plus 5 days, higher failure rates with typical use up to 7% were found in the study of Kost *et al.*²

Pregnancy should be always considered in women presenting with appropriate symptoms, even when Depo-Provera has been given regularly within the licensed use.

We agree with the suggestion of Drs Farmer and Patel that delayed diagnosis of an unplanned pregnancy could result in delay in seeking either abortion care or antenatal care.

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IUS as emergency contraception

I read with interest the article by Moss *et al.*¹ in the April 2009 issue of the journal about the understanding of intrauterine contraception by obstetric and gynaecology trainees.

I would question some of the article's conclusions. Without publishing the list of 'correct answers' it is not possible to know how I would have been rated on some of the questions. In particular 'An IUS is effective as emergency contraception' I would certainly have answered in the affirmative.

We all know that the intrauterine system (IUS) is not licensed as emergency contraception (EC) and never will be because of its cost, but if it were being planned as the ongoing method of contraception, it would certainly be effective as EC.

The postcoital intrauterine device (IUD) is not relying on its copper content for its efficacy. The copper inhibits sperm motility and the ability to fertilise the ovum. When it is fitted after sex, it is relying only on its ability to prevent implantation. Therefore any IUD would be effective, including the IUS. It therefore follows that it would be safe to fit the IUS on any day up to the estimated time of possible implantation – Day 19 in a 28-day cycle. It would not of course be the ideal time in the cycle, but might well prevent an unplanned pregnancy in a patient where you are not certain that she will return at a more ideal time.

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Reference

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Reply

The Clinical Effectiveness Unit (CEU) would like to refute the suggestion in Dr Devonald's letter¹ that the levonorgestrel-releasing intrauterine system (LNG-IUS, Mirena®) can be used for emergency contraception (EC). There is no evidence that the LNG-IUS is effective as EC and it is not licensed for such use.

The copper-bearing intrauterine device (Cu-IUD) is thought to act immediately by inhibiting sperm and ovum viability or preventing implantation.² The LNG-IUS has a different contraceptive mechanism of action that relies on hormonal effects on the endometrium, cervical mucus and uterine transport, and thus has a delayed onset.^{2,3} This is the rationale for advising additional contraception for 7 days if a LNG-IUS is inserted after Day 7.³ Although progestogen hormone can delay ovulation, the levels released from the LNG-IUS are insufficient to act in the same way as oral progestogen-only EC.

Therefore, as stated in CEU Guidance, we recommend that only copper-bearing devices should be used for EC.⁴

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Non-palpable implant removal

We were interested to read the comprehensive commentary on 'UK provision for non-palpable implants'¹ where the author recommends that "deep Implanon® removers" should remove at least 12 deep implants each year to maintain surgical skills.

The commentary did not elaborate on the basis for setting the standard at 12 removals per year or present the evidence to support the target. Deep (non-palpable) implants and difficult to remove implants (where attempts at removing using the push technique have failed) require different levels of competence and indeed the facilities required for removal may be different. Implanon was introduced in the UK in 1999. Of more than 150 000 implants fitted in the UK in 2007, the marketing company (Schering-Plough/Organon Laboratories) report a non-palpable rate of 0.69%, which, in absolute terms will be quite small numbers (Rakesh Patel, personal communication, 2009). We would like to suggest that if a competency target is to be used, definition of the competency area (non-palpable implants) and the referral pathway to national referral centres or individuals and the impact on access to such a service should be carefully considered. A large number of health professionals have acquired skills and experience in removal of deep implants and may not require removing 12 per year to maintain their skills.

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Reference

- 1 Mansour D. UK provision for removal of non-palpable contraceptive implants. *J Fam Plann Reprod Health Care* 2009; **35**: 3–4.

Reply

Thank you for your interest in the commentary on UK provision for non-palpable implants.¹ Doctors often enquire about the number of 'deep' implant removals they should perform each year to maintain their competence. The setting of 12 deep removals a year is based on personal experience and discussion with trainees, who have undertaken the necessary ultrasound and surgical training to remove palpable implants. Anecdotally, location and implant removal times are longer in those who infrequently perform this procedure. If clinics are failing to see this number of women a year, then I would question whether the health professional can maintain their skills and suggest that referrals are centralised to a regional service.

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Contraception availability in China

When I started working in a small general practice in Nanjing in China, I was surprised to find out how limited was the choice of contraceptives. Many expatriate women would come to our clinic asking to be prescribed the same pills they had in their home countries but I was unable to obtain them from the local pharmacies. Having an interest in family planning and a desire to continue to advise and prescribe contraception, I decided to investigate the underlying reasons for the scarce contraceptive market.

The one-child policy it has adopted makes China a unique environment for family planning. It has been already reported that this policy may have contributed to the rapid economic growth.¹ However, it has also created an enormous pressure on women not to get pregnant. Chinese families traditionally disapprove of a child conceived out of wedlock and it can present a major administrative problem.

A lot of unmarried women opt for abortion if they get pregnant. In Cheng *et al.*'s study of 4547 young unmarried women seeking abortion, 47.7% of the current pregnancies were associated with non-use of any contraceptive method and 52.3% were related to contraceptive failure.² These findings support the idea that information on methods of contraception is not widely available to the target population.

In the 2006 survey of contraceptive knowledge of 8462 married couples, Chen *et al.* tested knowledge of eight methods of contraception, namely the intrauterine device (IUD), oral contraceptive pill (OCP), barrier

methods, injections, natural methods, withdrawal, vaginal douche ("irrigation") and the spermicidal sponge.³ They discovered that the majority of couples knew most about the irrigation method followed by the IUD, OCP, withdrawal, timing, injection and finally female condoms and sponges. Some 70.1% of couples were aware of more than five different contraceptive methods but condom use was the most familiar one.

Family Planning Bureaus (FPBs) are undertaking the task of delivering free contraception and information to women. Even though OCP can be obtained for free, there are a number of reasons why women do not want to take it.

1. There is a general belief that the side effects of the OCP outweigh its benefits and its use is discouraged.

2. Slim body image: it is important to be slim in Chinese culture and women are afraid of putting on weight after starting a hormonal method of contraception (HMC).

3. The importance of having regular periods makes progestogen methods an unpopular choice also.

When our clinic nurse tried to obtain information on OCP from the FPB she was told that this method is really not the best form of contraception. However, free OCP, condoms and implants were offered. Information on HMC is primarily available on the Internet.

We searched the information available on the Nanjing People Birth Control Bureau website⁴ and discovered a brief review of the main methods of family planning: OCP, IUD, injections and condoms, as well as information on sexually transmitted infections. Unfortunately, some of the facts were out of date and some were simply incorrect, such as the claim that OCP can treat HIV infection.

The most accepted and known forms of contraception are condoms, IUDs and natural methods. Before giving birth, condoms are the main method of contraception. After giving birth, IUDs are traditionally used.

The reasons for the reluctance to use HMC are a lack of information about the real side effects and an inability to make an informed choice. The FPB provides limited information and so advice is often sought from other family members and/or peer groups.

Another factor that should be taken into consideration is cultural shyness when it comes to talking about contraception. In general, Chinese women are reluctant to actively seek information on contraception from available resources. The present attitude of the public towards sex, contraception and sex education remains conservative. Current perceptions maintain the environment of false beliefs about the real advantages and drawbacks of HMC.

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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 137).