Contraceptive failure and the progestogen-only pill

The case report by Chandler and Nash1 in this issue of the Journal is interesting and highlights the need for trials of hormonal contraceptive use to include obese women.

The authors acknowledge that despite an apparent association between contraceptive failure and higher body weight in studies of a Norplant® prototype and a levonorgestrel-releasing vaginal ring, there is insufficient evidence to demonstrate reduced efficacy in heavier women using the progestogen-only pill (POP). Current guidance from the Faculty of Sexual and Reproductive Healthcare (FSRH)2 advises one progestogen-only pill (POP) per day irrespective of body weight. This recommendation is based on the evidence available at the time of publication and the consensus of the guideline development group.

The recent review of obesity and oral contraceptive failure by Trussell et al.3 lends further support to FSRH guidance. The authors conclude that they “found no convincing evidence that very heavy or obese women have a higher risk of oral contraceptive pill [combined and progestogen-only] failure during perfect use than thinner women, even with the lowest doses formulations”. Trussell and colleagues mention the difficulties of reliably measuring adherence and they speculate that OCs may be less forgiving of imperfect use among heavier women.

Given that long-acting reversible methods of contraception (LARC) are known to be highly effective and less dependent on adherence than OCs, LARC methods should be offered to all women, particularly following POP failure.

Louise Melvin, MRCOG, MFSRH
Director, FSRH Clinical Effectiveness Unit, and Consultant in Sexual and Reproductive Health, Sandysford, Glasgow, UK.
E-mail: louise.melvin@rnh.net

References

Lost IUD penetrating bladder wall

The incidence of uterine perforation following intrauterine device (IUD) insertion is reported to be approximately 1 in 1000 insertions.1 Misplaced IUDs can be diagnosed simply with speculum examination. Missing threads is the usual sign and may be due to unrecognised expulsion, enlarged uterus due to pregnancy, the IUD threads becoming occluded, or whether the IUD may transmigrate to the adjacent structures easily.2 Our patient also had multiple pregnancies after IUD insertion. It seems that subsequent pregnancies may have caused the IUD migration. The patient had three deliveries following IUD insertion.

Bleeding problems and menorrhagia are possible outcomes following IUD insertion; however, these symptoms should alert the clinician to other possible complications. Accompanying pelvic pain is also another sign of possible problems. Our patient had pelvic pain for 4 months following IUD insertion and did not attend for a check-up. Because she attributed this pelvic pain to the insertion procedure, the opportunity for an early diagnosis was lost.

Conversely, the patient sought medical help in order to discover whether the device had dropped out and this was associated with decreased pelvic pain following this painful period. Unfortunately, medical staff concurred with the patient’s stated belief that the IUD had dropped out, and so did not perform further investigations to confirm or refute this belief. Interestingly the patient experienced no problems afterwards, until the diagnosis of a misplaced IUD nearly 15 years later.

We believe that this is the first case of bladder perforation reported in the scientific literature. It is a matter of debate in this case as to whether the uterus was iatrogenically perforated or whether the IUD moved through the uterine wall during pregnancy. This case also demonstrates an uncommon localisation of an IUD and the close relationship between pelvic pain and IUD misplacement. This case also emphasises the need for regular check-ups following IUD insertion and the need to be suspicious of possible locations other than the uterus. Most importantly, an accurate diagnosis may facilitate the use of endoscopic techniques and result in minimally invasive treatment.

Mehmet Vural, MD
Assistant Professor, Department of Obstetrics and Gynecology, School of Medicine, Harran University, Sanliurfa, Turkey
E-mail: drmvural@yahoo.com

Harun Toy, MD
Assistant Professor, Department of Obstetrics and Gynecology, School of Medicine, Harran University, Sanliurfa, Turkey

Hakan Camuzcuoglu, MD
Assistant Professor, Department of Obstetrics and Gynecology, School of Medicine, Harran University, Sanliurfa, Turkey

Bural Sogin, MD
Doctor, Department of Obstetrics and Gynecology, School of Medicine, Harran University, Sanliurfa, Turkey

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Mehmet Vural, Harun Toy, Hakan Camuzcuoglu and Burak Sezgin

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