Needless contraception

We want to share with Journal readers a case that highlights the challenges of facilitating effective teamwork across organisational boundaries. Our patient was a 27-year-old woman who attained menarche at age 12 years followed by regular periods for 4 years. At the age of 16 years, she saw her general practitioner (GP) with oligomenorrhoea and was referred to secondary care. Initial investigations revealed raised follicle-stimulating hormone (FSH: 25.4 IU/l) and luteinising hormone (LH: 12.8 IU/l). Her estradiol (236 pmol/l) and prolactin (399 mU/l) levels were normal. Transvaginal ultrasound confirmed normal ovarian morphology. Repeat FSH and LH were 120 and 36.5 IU/l, consistent with premature ovarian failure (POF). However, the patient failed to attend for follow-up and moved away without knowledge of the results.

Shortly afterwards, when seeking contraception, she received Depo-Provera® in a community family planning clinic, which was continued for 9 years. Her oligomenorrhoea was not explored, being attributed to the long-acting progestogen. Six months after stopping Depo-Provera she consulted her GP due to ongoing secondary amenorrhoea. Further FSH and LH levels (170 and 40 IU/l and 133 and 32.5 IU/l, respectively) confirmed her previous diagnosis of ovarian failure. She had low estradiol (101 pmol/l) and progesterone (<0.6 nmol/l) levels but normal thyroid function and karyotyping. She was therefore counselled and commenced on hormone replacement therapy (HRT). A bone density scan found osteoporosis of lumbar spine and osteopenia of neck of femur.

The late diagnosis, unnecessary contraception, prospect of being infertile and the wider health implications have had a psychological impact on this woman, leaving her angry, and she has refused counselling. Options of egg donation and adoption have been broached and she remains under review. We believe that this case raises medical, ethical and risk-management issues.

First, a detailed menstrual history and investigations for oligomenorrhoea were clearly needed before hormonal contraception was offered. POF is usually asymptomatic apart from abnormal bleeding and timely diagnosis of POF facilitates investigations into causes, access to appropriate counselling, and medical treatment with HRT. Untreated POF is associated with osteoporosis, increased cardiovascular disease, dementia, cognitive decline, Parkinsonism, and all cause mortality.[1]

Second, the use of Depo-Provera was the wrong contraceptive choice for this patient. It should be used after

consideration of other methods and of the possible risk of loss of bone mineral density, which proved to be particularly pertinent in this case. Had the combined oral contraceptive pill been used instead in a woman heading towards POF it may have provided some protection against the resultant osteoporosis and osteopenia.

Third, we believe this case highlights the need for interagency communication, whether by a computerised system or by a robust clinical pathway. Clinics working in isolation, without full knowledge of a patient's prior medical history, risk missing vital information, duplicating results and delaying management. Informing patients of the importance of tests and possible diagnoses may enable them to take responsibility for their care and attend follow-up. The NHS Improvement Plan published in 2004 outlines ways in which the use of information and information technology (IT) can drive improvements in patient care, and is a step in this direction.[2] The use of health IT to resolve the crisis in communication inherent within the fragmented service environment of medical care is becoming evident. The Electronic Health Record is an important application of information and communication technologies to the health care sector, expected to benefit patients, professionals, organisations and the population as a whole.[3]

In summary, we wish to highlight this case to Journal readers to demonstrate that interdisciplinary communication is critical for safe and effective care, yet is sometimes inadequately provided, with serious consequences. Simple history taking, acting on requested investigations and communicating them effectively is integral to clinical work. They are powerful ways of reducing medical, psychological, financial and legal costs arising from delayed diagnosis.

Emma Cordle, MBChB, BSc

ST 1, Department of Obstetrics and Gynaecology, North Middlesex University Hospital, London, UK; emma.cordle@doctors.org.uk

Abha Govind, MFSRH, FRCOG

Consultant, Department of Obstetrics and Gynaecology, North Middlesex University Hospital, London, UK; Abha.Govind@nmh.nhs.uk

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REFERENCES

1 **Rees M**, Hope S, Stevenson J. British Menopause Society Council Factsheet: Premature Menopause. 2008. http://www.thebms.org.uk/factdetail.php?id=1 [accessed 18 September 2010].
2 **Department of Health.** *The NHS Improvement Plan: Putting People at the Heart of Public Services.* 2004. http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/@ps/documents/digitalasset/dh_118572.pdf [accessed 18 September 2010].
3 **Hesse BW**, Hanna C, Massett HA, *et al.* Outside the box: will information technology be a viable intervention to improve the quality of cancer care? *J Natl Cancer Inst Monographs* 2010;**2010**:81–89.