

## NEWS ROUNDUP

## News from the CEU

In this edition of the Journal can be found the Clinical Effectiveness Unit (CEU)'s new evidence-based Guidance on Contraceptive Choices for Women with Inflammatory Bowel Disease (page 127). This Guidance on contraception for women with Crohn's disease and ulcerative colitis was developed from current evidence and with the essential input of a Multidisciplinary Expert Group. The CEU is currently looking for Expert Group Members for future Guidance documents. Any health care professionals who may be interested in taking part should contact the CEU at the address below for more information. Look out for an update on Guidance for First Pill Prescription in the next edition of the Journal.

An example of an evidence-based response to a clinical enquiry can also be found in this issue, in the series of most frequently asked questions. This month the CEU provides guidance on the use of two progestogen-only pills by women who weigh >70 kg. Members can access the Clinical Enquiry Service at the address below. The CEU aims to provide an evidence-based response to a clinical query within 7 working days and in order to achieve this the CEU can presently only accept queries from members of the Faculty of Family Planning and Reproductive Health Care (FFPRHC). The CEU can provide an evidence-based answer to one specific clinical problem, but are unable to answer questions relating to individual patients or to provide answers immediately. The CEU is presently unable to provide a literature search facility for health professionals who are writing dissertations or research papers. The CEU will

continue to develop the Members Clinical Enquiry Service this year and are aiming to provide a searchable facility of all enquiries on the Faculty website which will be accessible to all members.

The CEU is currently developing an evidence-based review of the new combined contraceptive patch, Evra (Janssen-Cilag Ltd), which is to be launched this summer.

The Emergency Contraception Guidance document, which was published in the April 2003 issue of the Journal, is now available on the Faculty website. The CEU have a limited number of offprints which can be obtained free of charge whilst stocks last.

Members of the CEU are also available to speak at regional Contraceptive Updates. If anyone would like a presentation on the CEU's work then they should contact the CEU at [www.fpp.ceu@abdn.ac.uk](mailto:www.fpp.ceu@abdn.ac.uk) or direct enquires to c/o CEU, Room 63, Aberdeen Maternity Hospital, Cornhill Road, Aberdeen AB25 2ZL, UK. Tel: +44 (0) 1224 553623. Fax: +44 (0) 1224 551081.

### The WHO Selected Practice Recommendations for Contraceptive Use

The World Health Organization (WHO) *Selected Practice Recommendations for Contraceptive Use* was published in 2002 and provides systematically developed recommendations for the safe and effective use of contraception. Some of the recommendations are at odds with accepted UK clinical practice. For example, hormonal contraception such as the combined oral contraceptive pill (COC) and progestogen-only pill (POP) can be started up to and including Day 5 of the menstrual cycle, without the need for additional contraception. Injectable progestogens and progestogen-only implants can be started up to and including Day 7 without the need for

additional contraception. Following a systematic review by the WHO, the risk of ovulation was felt to be negligible with these starting regimens. Hormonal methods may also be started at any time after the onset of menstruation, as long as one can be reasonably certain there has been no risk of pregnancy up to this time. When COC, implants or injectables are started after Day 5, additional contraceptive protection is required for 7 days or until seven consecutive pills have been taken. When POP is started after Day 5, additional contraceptive protection is required until two consecutive pills have been taken.

The WHO *Selected Practice Recommendations* were developed for use worldwide to facilitate access to effective contraceptive methods. Relaxing the traditional rules may facilitate the use of effective methods by couples in developing countries where pregnancy is associated with high maternal and perinatal morbidity and mortality. The relaxation of these rules, however, may lead to unintended pregnancy in a very small number of women. After counselling regarding variations in timing of ovulation and cycle length, some women may choose to use barrier methods when starting hormonal methods on any day other than Day 1 or 2. The WHO recommendations suggest that in circumstances where women may not wish to use additional protection they may be advised that the risk of ovulation is negligible if starting up to and including Day 5. A pragmatic approach to contraceptive provision should be taken. Some of the recommendations depart from generally accepted UK clinical practice. In view of this, the Faculty of Family Planning and Reproductive Healthcare (FFPRHC) held a consensus meeting of experts to develop a UK version of the WHO *Selected Practice Recommendations for Contraceptive Use* which will be available on the Faculty website later this summer.

## JOURNAL CLUB

**Surfing on the morning after: analysis of an emergency contraception website.** Gainer E, Sollet C, Ulmann M, et al. *Contraception* 2003; **67**: 195–199

This is a review of activity on a bilingual website in France to support the over-the-counter (OTC) sales of progestogen-only emergency contraception (POEC) (equivalent to Levonelle® but with the brand name Norlevo® in France). The website was developed by the company that markets Norlevo in France.

POEC was licensed for OTC sale shortly after its first appearance in France in 1999. It is also available through school nurses, and since December 2000 has been supplied free of charge in pharmacies to under 18-year-olds. Only 3% of POEC is supplied on prescription in France.

The website consists of a home page, general information, product information, school nurse information, frequently asked questions, company home page and a contact form where surfers can submit a question to be answered by a medical professional. The website was monitored for 2 years from 1 January 2000 to 31 December 2001.

A total of 70.9% of hits were from French users. Only this data was analysed. Use of the site increased from 2134 visitors per week in January 2000 to 5539 visitors per week in December 2001. Over 500 questions were submitted; 115 were from users, and the rest were from health professionals and teachers or libraries. The most common question from users of the method was

about bleeding patterns, while most professionals asked about its mode of action.

The authors argue that a website may be a useful way of educating users and getting their feedback when a product is available OTC. However, a recent visit to their website ([www.norlevo.com](http://www.norlevo.com) accessed 1 April 2003) does not entirely support this theory. The frequently asked questions page does not put bleeding problems in their top 41 questions. Although much of the information is sound, there is a question about the advice regarding an intrauterine device (IUD). Their recommendation is that the user should wait until their next menstrual cycle to get one fitted. Ideally a website would mention the option of postcoital IUD insertion.

Clearly the French situation is unusual, with very few women choosing to obtain emergency contraception from a health professional. Some of the questions submitted to the website might be more appropriately addressed in a medical consultation. The authors raise concerns about this issue. This may mean that lessons from this website are less applicable to the current UK situation where only 30% of Levonelle is supplied OTC and 70% is prescribed.

Reviewed by **Judy Murty**, DRCOG, MFFP SCMO, *Contraceptive and Sexual Health Services, Leeds, UK*

**Pregnancies diagnosed during Depo-Provera use.** Borgatta L, Murthy A, Chuang C, et al. *Contraception* 2002; **66**: 169–172

This paper reviews pregnancies occurring in Depo-Provera users at centres run by the Planned Parenthood Federation of America. The authors

estimated the rate of pregnancy from the 402 cases reported in the period 1994–1998 to be 0.42/1000 women-years. They emphasise this was not necessarily an accurate reflection of the true failure rate because of the study design.

Only 47% of the women who became pregnant reported symptoms of pregnancy, 19% of women received a second injection during pregnancy and 46% of pregnancies were not detected until the second trimester. Nevertheless, pregnancy symptoms were the most common reason for detection of pregnancy.

Where the conception date could be estimated, 55% of women probably conceived before or immediately after their first injection; many of these women had received their first injection beyond the first 5 days of their cycle. The remaining 45% of women had conceived once established on the method but as many as half of these women may have had an injection interval exceeding 12 weeks.

There were a few ectopic pregnancies, at a rate of 1.5% of all pregnancies reported.

This study was not designed to look at teratogenesis, however the authors noted that they had received no reports of fetal anomalies.

The main lesson from this study is that a small number of women get pregnant unexpectedly while using Depo-Provera. Very commonly this relates to undetected early pregnancy before Depo-Provera is initiated or to inappropriately timed injections. Pregnancy in Depo-Provera users is usually detected in the second trimester; if a woman feels she may be pregnant a pregnancy test should be done.

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