The authors used a postal survey to 3916 women aged 18–49 randomly selected from the Oxfordshire Health Authority register. Chronic pelvic pain was defined as recurrent or constant pelvic pain of at least 6 months’ duration and unrelated to periods, intercourse or pregnancy. Women reporting dysmenorrhoea alone were used as a comparison group. Case subgroups were recent consultants, past consultants and non-consultants.

Findings showed a 3-month prevalence of 24% (95% CI = 22.1% to 25.8%). One third of sufferers reported pain starting more than 5 years ago. Recent consultants were more affected by pain severity, sleep quality, pain-related absences from work and mental and physical health scores.

Non-consulters (41%) did not differ from women in terms of symptom-related behaviour. However, 31% of chronic pelvic pain sufferers were found to have a high rate of symptom-related anxiety compared to dysmenorrhoea sufferers – even in the 41% who did not consult. The authors conclude that the finding of high symptom-related anxiety in chronic pain sufferers emphasises the need for more information about this common condition.


This is an extensive review of the subject. The authors emphasise that the aetiology is uncertain and that symptoms can range widely with many cases being asymptomatic. The incidence in the population is uncertain, but was found to be 8.4% of all women attending GUM clinics. Risk factors, which are not necessarily aetiological factors, include smoking, black ethnicity, use of vaginal douches and age over 25 years. However, a study in inner London showed that when adjusted for douching, black race was no longer significantly associated.

The significance of intra-uterine contraception is debated. Studies in the UK, Belgium and the USA suggest an association, but this may be due to intra-uterine device (IUD) use being more common in older women. Some studies show an association with early age of first intercourse and increasing number of sexual partners. However, bacterial vaginosis can occur in virgins. There is evidence that sexual intercourse with a new sexual partner provokes symptoms. Treatment of the partner showed no benefit in five of six trials.

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This prospective study recruited 221 women who were attempting to conceive. The study estimated the probability of pregnancy relative to intercourse on a given day of the menstrual cycle. The day of ovulation was estimated on the basis of daily patterns of hormones.

The study confirms that most women ovulate around Day 14, but a number of women, especially those with irregular cycles, can ovulate 6 weeks after their last menstruation. Post-coital contraception may be indicated even when ovulation has occurred late in the cycle.


This study investigated the side effects of a low-dose oral contraceptive containing 20 µg ethinyl estradiol/100 µg levonorgestrel (EE/LNG) compared with placebo. Seven hundred and twenty-one women were enrolled for six cycles. There was no difference between the two groups for weight gain or side effects such as headache, migraine, nausea, vomiting or breast pain. Disorders of menstruation and allergic reactions were reported more in the EE/LNG group.

The authors conclude that the study demonstrates that the low dose oral contraceptive does not produce a weight gain and is not associated with side effects usually attributed to the combined oral contraceptive.

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Ashok PW, Wagaarachchi PT, Flett GM, Templeton A. Mifepristone as a late post-coital contraceptive. *Hum Reprod* 2001; 16: 72–75.****

Canadian and Scottish studies investigate the efficacy of hormonal emergency contraception when used between 72 and 120 hours after unprotected intercourse. Both are small studies so that the efficacy results are imprecise, but there is a clear indication from both that the treatments significantly reduce the chance of pregnancy when given after the end of the normal 0-72 hour window.

The Canadian study compares users of the Yuzpe regimen in the normal time-frame with those treated after 72 hours. The treatment prevented 87% of expected pregnancies in both groups, but the confidence intervals were very wide. It is likely that the efficacy beyond 72 hours is less than in the normal time-frame.

Women in the Scottish study were all > 72 hours when seen, and those who declined IUD insertion were given mifepristone 200mg. Mifepristone prevented 85% of pregnancies and the IUD 100%. However, the single pregnancy in the mifepristone group was attributable to unprotected intercourse subsequent to treatment.

These new studies and previous studies on use of mifepristone up to 120 hours indicate that there is worthwhile efficacy after 72 hours. Far larger studies are needed to give a statistically significant difference between efficacy at < 72 and 72+ hours, partly because the latter group is small (only 10-20% of women are treated at > 72 hours).

The product licence for Levonelle-2 is for use only up to 72 hours after intercourse. In the past most of us have dismissed the idea of use of hormonal methods after 72 hours. If IUD insertion is not acceptable to the client, or not possible or desirable (as is often the case in young nulliparas), then many women have gone away with nothing. With the caveat that explanations to the client are needed about extrapolation from studies of other hormones, probable lower efficacy than quoted figures and about use without the licence, these studies justify extending use to 72-120 hours for selected cases.

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