# FROM THE JOURNALS

Whitford D, Karim M, Thompson G. **Attitudes of patients towards the use of chaperones in primary care (Brief report).** *BJGP* 2001; **51**: 381–383.*

The authors used focus groups of male and female patients from three regional practices, none of which at that time offered chaperones. Both sexes were studied as the percentage of female general practitioners (GPs) has risen dramatically (from 20% in 1988 to 33% in 1998, and still rising).

Fifteen percent always wanted a chaperone and 15% never wanted a chaperone. Men held slightly firmer views than women, and a desire for a chaperone by a considerable minority of men whilst being examined by a female professional was found.

The General Medical Council (GMC) advises that a chaperone is always offered; this was interpreted as an indication of respect for the patient by the GP (which may well reduce the rate of complaints), but rigid imposition of a chaperone was seen as paternalistic and lacking in respect. Indeed, this was an emerging issue in itself.

The wide variation in patient wishes is seen as an area for shared decision making by patient and doctor.

Who, though, will be able to be a male chaperone for a male patient in primary care? Receptionists are unacceptable, and the majority of them are female!

Richardson J, Freder G, Eldridge S, et al. **Women who experience domestic violence and women survivors of childhood sexual abuse: A survey of health professionals' attitudes and clinical practice.** *BJGPs* 2001; **51**: 468–473.*

A survey was sent to all 700 GPs, practice nurses and health visitors in East London and City Health Authority area in 1998. The response rate was 57%, with women GPs and members of the Royal College of General Practitioner's (RCGP) more likely to respond.

Eighty-one percent thought that the adult sequalae of childhood sexual abuse are a health care issue, and 84% that domestic violence has health sequalae. Women professionals were more likely to think this than men. Eighty percent also disagreed that there was nothing health professionals could do to help.

Only 10% of respondents thought that women should be routinely screened for child sexual abuse, whilst 32% of health visitors, 15% of practice nurses and 14% of GPs thought that routine questioning concerning domestic violence was necessary.

Twenty-eight percent had received training on childhood sexual abuse, and 48% some training on domestic violence, but most wanted to receive training.

The authors conclude that these two life events are considered to have health implications, but that routine screening about these issues should not be prioritised until benefit has been established.

Zondervan K, Yudkin P, Vessey M, et al. **The community prevalence of chronic pelvic pain in women and associated illness behaviour.** *BJGP* 2001; **51**: 541–548.*

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 consulters, past consulters and non-consulters.

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 consulters 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.

Tobin C, Guy S, Jeffrey G. **Chlamydia trachomatis: opportunistic screening in primary care.** *BJGP* 2001; **51**: 565–567.*

A West Yorkshire practice was the location for screening all women aged 13-24 years (n = 572) who were thought to be sexually active by receiving contraception from the GP or being known to be pregnant. First void urine was tested by polymerase chain reaction.

A prevalence of 10.9% for chlamydial genital infections was found for the year Dec 1998-Nov 1999. All were treated by the GPs and 12 out of 14 index cases and nine out of 12 named contacts agreed to attend the genito-urinary medicine (GUM) clinic (a 20-mile round trip). No other sexually transmitted disease (STD) was diagnosed.

Seventy-eight percent of those eligible were invited to submit urine, but 60% chose not to after counselling.

The authors conclude that it is possible to undertake *Chlamydia* screening in primary care (in accordance with the Clinical Medical Officer's [CMO's] expert advisory group recommendations). Uptake might have been higher if a nation-wide campaign emphasising the importance of *Chlamydia* was undertaken. In addition, this survey did not study sexually active members of the target group who did not consult the GP for contraception or pregnancy care, so the true prevalence rate is probably higher.

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Vandenbroucke JP, Rosing J, et al. **Oral contraception and the risk of venous thrombosis.** *New Engl J Med* 2001; **344**: 1527–1535.**

This is an extensive review of the subject. The authors conclude that the risk of venous thrombosis with third generation pills is such that they should not be the first choice when prescribing. They also conclude that screening for factor V Leiden is not required in the absence of a significant family or personal history, because it would take half a million tests to avoid one death from pulmonary embolism.

Morris M, Nicoll A, et al. **Bacterial vaginosis.** *BJOG* 2001; **108**: 439–450.**

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 uncertain. Studies in Sweden, 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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Wilcox AJ, Dunson DB, Weinberg CR, et al. **Likelihood of conception with a single act of intercourse: Providing benchmark rates for assessment of post-coital contraception.** *Contraception* 2001; **63**: 211–215.***

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.

Coney P, Washenik K, Langley RGB, et al. **Weight change and adverse event incidence with low-dose oral contraceptive: Two randomised, placebo-controlled trials.** *Contraception* 2001; **63**: 297–302.***

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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Rodrigues I, Grou F, Joly J. **Effectiveness of emergency contraceptive pills between 72 and 120 hours after unprotected sexual intercourse.** *Am J Obstet Gynecol* 2001; **184**: 531–537.****

Ashok PW, Wagaarachchi PT, Flett GM, Templeton A. **Mifepristone as a late post-coital contraceptive.** *Hum Repro* 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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