
In this study from Aberdeen, UK, 500 women were randomly assigned to mifepristone 100 mg and 500 to the Yuzpe regimen for emergency contraception within 72 hours of unprotected intercourse. All participants answered a questionnaire and a follow-up appointment. A comparison was made of efficacy, side effects and patient acceptability, and possible confounding factors were taken into account.

Crude pregnancy rates as well as expected and prevented pregnancy rates were compared to assess efficacy. Seventeen pregnancies occurred in the Yuzpe group (all of which were considered to be method failures) giving a pregnancy rate of 3.6%. Only three pregnancies occurred in the mifepristone group giving a pregnancy rate of 0.6%. The difference in the rates was highly significant. Two of the three mifepristone pregnancies were considered to be user failures because conception must have occurred after the emergency contraception. If they are excluded mifepristone is seen to be even more significantly effective. Comparison of expected and actual pregnancy rates showed that mifepristone prevented 92% of pregnancies while Yuzpe prevented 56%. If the two user failures are excluded the mifepristone group prevented 97%.

Side effects were less with mifepristone except that delay of the next menstruation was more common in the mifepristone group. Satisfaction was significantly better with the mifepristone group.

Now that progestogen-only emergency contraception has taken over from the Yuzpe regime the most useful comparison would be between mifepristone and progestogen-only pills. The authors of this study are aware of five such studies and five to those reported for levonorgestrel in the World Health Organization (WHO) study of 1998. Another of the authors’ own studies has shown that mifepristone 200 mg is effective up to 120 hours after unprotected intercourse. A meta-analysis of data from 54 studies suggested a slightly increased risk, the relative risk being 1.24.

An editorial in the same issue (N Engl J Med. 2002; 346: 2078–2079) comments on the Marchbanks study under the title ‘Good News about Oral Contraceptives’. This points out some possible weaknesses of the meta-analysis and observes that the present study clearly confirms the CASH study. Indeed the CASH study suggested that further study to determine late effects may take a decade or more to resolve. Six years later the present study provides that resolution.

Reviewed by Mr Michael Cox, FRCOG, MFFP
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How can we develop a cost-effective quality cervical screening programme? Wilson S, Lester H. Br J Gen Pract 2002; 52: 485–490

Currently 90% of women are screened in the general practice setting. The authors propose that too many women are being screened too often. Greater quality rather than quantity is needed. They suggest that the current programme to cover 25-50 years old only five years would provide substantial savings. These savings could be used to increase the quality of screening of this relatively rare disease. ‘Never-screened’ women in lower social classes constitute the group that justifies most extra targeting instead.

Reviewed by Penny Watson, MFFP, MHP
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This was a prospective study to examine the effects of intrauterine devices (IUDs) on pelvic inflammatory disease (PID), the detection of microorganisms from the culture of removed IUDs and the incidence of uncomplicated genital tract infections. Previous studies had shown the direct association between PID and the use of an IUD to be scarce.

Two hundred and fifty women were recruited and each was fitted with a copper Multiload 250. The end point of the study for each woman was the evidence of PID or after removal at 3 years. Women were excluded if they had an allergic reaction to copper, history of ectopic pregnancy, history of sexually transmitted infection (STI), history of PID, genital tract malformation, genital malignant disease or blood clotting disorders. It would seem that the population was very select, especially in relation to the exclusion of data from 54 studies suggested that the population was representative of their IUD users in the area.

The women were all tested for STIs before fitting and were only given antibiotics if necessary. The vaginal and endocervical swabs showed a positive culture rate of 60.5% before fitting and 89.5% at follow-up. The cultures showed the normal spectrum of vaginal organisms with Gardnerella vaginalis most prominent before fitting and Candida albicans at follow-up. There were no STIs detected. Smears done before and after fitting were negative for Actinomyces. There were no cases of PID reported.

The IUDs were removed at 3 years and their threads were removed. Both were sent for culture. The cultures showed positive in 94.5% cases. The most common organisms were Staphylococcus coagulase-negative, Escherichia coli and Enterobacter faecalis. The authors felt that this high infection rate was due to the IUD being contaminated at the time of removal though the cervix and vagina.

The study seems to fail in its aim as there were no cases of PID reported. This is probably due to their selection of women and an absence of STIs in this population. Even so, it shows high percentages of positive culture results both before and after fitting and nearly every IUD was contaminated. It gives reassurance in that women who are carefully selected for IUD fitting and have no risk factors for STIs, even if there appears to be an abundance of commensal organisms, these do not contribute to PID.

Reviewed by Judy Murty, DRCOG, MFFP
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This study aggregated seven recent epidemiological studies that investigated the risk of myocardial infarction (MI) in users of second- and third-generation combined oral contraceptives. Together the seven studies involved nearly 6500 women from 1996, and the authors compared the results with those from earlier reports between 1966 and 1995. The aggregated results confirm that all the oral contraceptives studied did not show an excess of risk for MI when used according to their regulatory labels. MI is rare in women of reproductive age and the absolute rate of occurrence reported in these studies was even lower than the rates reported in studies between 1966 and 1995. Not all the studies in this aggregation reported absolute rates, but the authors estimated from the studies that the rate in those women on oral contraceptives (either second- or third-generation) could not be more than 0.6–1.8 per 100 000 women per year. The 22 studies from 1966 to 1995 gave rates of 1.5 in non-pill users and 13 in pill users (per 100 000 women per year).

The data confirm that women with risk factors should be treated with caution. Smoking and hypertension are major risk factors for MI. The authors’ interpretation of the data from this aggregation is that for women with minor risk factors such as a family history of MI, the use of a third-generation oral contraceptives may be slightly more favourable than that of second-generation oral contraceptives. In practice, it seems likely that this study will make little impact on prescribing. It may help clinicians to give fuller information to women with minor risk factors and help in the choice of contraception. For the majority of women, the study shows that the risk of a MI is so low that it is unlikely to play a major role in the discussion of the relative benefits and risks of particular contraceptives.

Report and comment by Dr Gill Wakesley, MD, MFFP
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