LETTERS

Size does matter and Homeopathic treatment of premenstrual symptoms

Madam

I am somewhat concerned that in the same issue of the Journal as the statistical paper entitled 'Size does matter'1 there was an Overview on 'Homeopathy treatments for premenstrual symptoms'2 which may be considered to have depended on evidence that contradicted the statistical paper. I would be careful for your opinion as to the reliability of the one clinical trial by Yakir et al.3 which was cited as evidence in favour of homeopathy. I would like to make clear that my motivation is not to discredit homeopathy.

1. The Overview refers to the 'recent' trial by Yakir et al. It was actually carried out in 1992–1994 and not published until 2001.
2. The Overview refers to there being 20 women in the study but actually only 19 completed the study.
3. The Yakir et al. study claims 90% of the homeopathy group had improvement – actually it was 91%, i.e. even more favourable to homeopathy than was claimed.

Madam

Yakir et al. set an arbitrary improvement level of 30% of the menstrual distress questionnaire to determine effectiveness of therapy resulting in three of the placebo group improving by 20. However, Figure 2 shows that five of the placebo group had improved.

5. While claiming homeopathy effective they admit under Outcome(s) that 'the between group difference fell just short of statistical significance'.
6. The study certainly suggests the possibility that homeopathy is effective so why no larger placebo trial 9 years later?

My main concern is that our Journal has given credibility to the effectiveness of homeopathy in the management of premenstrual syndrome on the basis of inadequate evidence. What do you think?

Michael Cox, Member of the Editorial Advisory Board, Journal of Family Planning and Reproductive Health Care and Consultant Obstetrician and Gynaecologist (Retired), Nuneaton, UK

Reply

Thank you for your letter regarding the above mentioned papers. I agree that the fourth key message point in the Jones article 'A randomised, controlled double-blind trial published in 2001 has confirmed the positive outcome of the previous research experience' is not substantiated. The findings of one, very small, randomised controlled trial are not enough to support such a statement. The text of the Jones article refers to the Yakir et al. study as a pilot. Although, technically, the Yakir et al. study was not a pilot, this terminology should have alerted your readers to the fact that the results of a single, very small, randomised controlled trial are not enough to support such a statement. The findings of one, very small, randomised controlled trial are not enough to substantiate. The findings of one, very small, randomised controlled trial are not enough to be assessed. Randomisation of 23 patients will not ensure comparable groups, albeit any difference will be unmasked purely by chance. There is still the potential for differences in the characteristics of the women in the two groups to have had an unmeasured effect on between group comparisons. The final sentence in the Results section of the Yakir et al. paper states, 'No secondary or demographic characteristics affected response to treatment. This is very likely to be due to a lack of power rather than no effect, although this cannot be assessed as no data are provided.

In summary, I agree with you that the 'evidence' behind the fourth key message point in the Jones paper is not of sufficient quality or size to justify this statement.

Jill Mollison, Statistical Advisor, Journal of Family Planning and Reproductive Health Care and Biostatistician Research Fellow, Department of Public Health, Medical School, University of Aberdeen, Aberdeen, UK

More on how to remove a Chinese IUD

Madam

Stillwell's letter1 in the April issue of the Journal prompted me to write to you with my findings and experience with this subject.

Of the 156 million intrauterine device (IUD) users worldwide, 106 million are in China where the IUD is used by 45% of married women and sterilisation used less commonly. A meta-analysis by Li Yong et al. of 22 published and unpublished studies compared the efficacy of the steel ring IUD to the copper-bearing IUD4 and found failure rates of 19% compared to 5.9% with copper IUDs and an expulsion rate of 16.5% versus 5.8%. The State Family Planning Commission advised against its manufacture in 1993.

Information obtained by e-mail from China, via a Chinese patient, included pictures and instructions on insertion and removal of steel rings. The rings are fitted using a ‘fitting fork’ or ‘fitting pliers’ which carry the ring in the uterus. Removal is performed using a hook.

If the ring is stuck in the uterus and cervix then it is cut in half between two haemostat forceps before being cut out. This is preceded by cervical dilatation.

A literature search revealed no relevant information about removal of these devices in the existing Faculty of Family Planning and Reproductive Health Care (FFPRHC) and Royal College of Obstetricians and Gynaecologists (RCOG) Guidance documents, the National Guidelines Clearing House or World Health Organization (WHO) publication, Improving Access to Quality Care in Family Planning - Selected Practice Recommendations for Contraceptive Use, 2002.

The Clinical Effectiveness Unit (CEU) of the FFPRHC helped by conducting a MEDLINE and EMBASE search for the period 1996–2002. They found one paper recommending the use of three-dimensional ultrasound imaging to locate and detect the type of IUD and successful removal in 26/28 cases by hysteroscopy, laparoscopy or laparotomy.5

When faced with a thread-free device, there are two instruments available: the rigid uterine hook similar to that used by the author of the reference paper and the flexible rocket IUD-removing forceps.6 In my experience I have found the forceps superior to the uterine hook, allowing more control of the ring. Here is giving more confidence. They also have the advantage that any part of the IUD can be grasped and brought down.

I hope others will try the technique for themselves. The most successful instrument will be the one with which the operator is most familiar and confident to use.

I would like to thank the CEU for their literature search and my patient for providing the information and pictures you requested. For more information about forceps, please contact the author.

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Vasectomy techniques

Madam

There are a few points that we would like to make regarding the paper comparing scalpel and the electrocauterity no-scalpel vasectomy (ENSV) techniques.7

We believe that the phrase ‘no-scalpel vasectomy’ is a misnomer because, although it implies that no scalpel is used to incise the skin, a special dissecting clamp or, as in this case, electrocauterity is used to breach the skin and subcutaneous tissues to gain access to the vas. Whichever method is used the incision in the skin has to be at least twice the diameter of the vas that is being exteriorised.

We use two Allis’ forceps or a single Allis forceps and a skin hook to deliver a loop of vas through an incision made by a Number 11 blade. We assessed some of the parameters described in the paper with the following results:

1. Using a visual analogue scale (0–10) to measure pain during the operation it was found that the average score for pain during surgery was 2.52 (range 0–9). The duration of analgesic use after vasectomy was for a mean of 3.6 days (range 0–1.4 days).
2. Patients returned to work on average 4.89 days after surgery (range 1.17–11), although, as in the Black and Francombe paper, not all the time off work was related to the operation.
3. In a survey of patient satisfaction 68% graded the service as excellent and 26% as good, while in a previous assessment these figures were 53% and 43%, respectively.

We have used this technique a few thousand times and believe that the single incision mini-vasectomy is as good as the ENSV procedure.

References


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References


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