LETTERS
Pharmacists and POEC

Madam

We read with interest and some surprise the description of the 3-day training course provided in Lambeth, Southwark and Lewisham, London1 for pharmacists, enabling them to issue progestogen-only emergency contraception (POEC) using a Patient Group Direction (PGD). First, do they need that much training? As ‘very streetwise’ professionals, do they need so much training to issue a drug, when the World Health Organization (WHO) Medical Eligibility Criteria for Contraceptive Use2 advise that there are no medical contraindications to POEC and the Faculty’s own guidelines also state that there are no absolute contraindications to POEC, although caution should be used in women with porphyria or severe liver disease.3 Second, how on earth did they find the time?4

We were also anxious that the participants should see themselves as part of a seamless service including all sexual health providers, and had no idea of what demand might be (it has in fact reached 10 000 supplies a year across our very deprived inner city area).

The sessions were deemed to be valuable, fun and useful and, with a 24-hour sexual health consultant on-call rota, and several young people’s outreach health services throughout the county, to whom they can refer, the pharmacists here feel fully supported and valued.

We believe barriers should not be created to women accessing emergency contraception particularly the high price of over-the-counter (OTC) products. Decreasing the cost of OTC Levonelle® to that of a prescription would increase accessibility and sales. We should like to see school girls trained and able to issue POEC and for easier access for all women who need this method of contraception.

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References

Reply
We are grateful for the interest shown in our training.

After the appraisal of the first course, we did reduce the course to a 2-day one, as is stated in the discussion on page 21. Funding for locums was from the local Health Action Zone, although finding locums was a problem for the pharmacists concerned.

The main point to note is that the first course was held in early 2000, when the idea of pharmacists doing this work was very new (we were only the second project in the UK to go live) and when over-the-counter sale had not yet been approved. Public and professional reaction was untested, and a great deal of time was spent helping the pharmacists concerned to feel confident if challenged about their right to supply emergency hormonal contraception. The wisdom of this was shown when the Daily Mail published an inaccurate story, as detailed in the paper; the pharmacists concerned had an extremely unpleasant experience but coped amazingly well. We were also anxious that the participants should see themselves as part of a seamless service including all sexual health providers, and had no idea of what demand might be (it has in fact reached 10 000 supplies a year across our very deprived inner city area).

Perhaps the moral of this is that today’s daring innovation is tomorrow’s bolder vision, as every department that has set up a PGD has in fact reached 10 000 supplies a year across our very deprived inner city area.

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Ectopic pregnancy following use of progestogen-only ECPs

Madam

We read with great interest the editorial about ectopic pregnancy (EP) following use of progestogen-only emergency contraceptive pills (ECPs).1 The authors note that 12 EPs in women who used levonorgestrel ECPs have been reported in the UK and that a handful of additional cases have been reported in other countries. As the authors acknowledge, this information cannot be used to calculate the probability that a pregnancy occurring after use of the treatment will be ectopic because the total number of pregnancies needed for the denominator of the calculation is unknown. Nevertheless, based on these case reports, Britain’s Committee on Safety of Medicines (CSM) has advised that if a woman who has used progestogen-only ECPs becomes pregnant, “the possibility of an ectopic pregnancy should be considered”.2

Data from clinical trials of ECPs can yield an accurate estimate of the rate of EP because pregnancies in these trials are systematically documented and thus provide a valid denominator for the rate. Through a search of the published literature, we identified five clinical trials of levonorgestrel-only ECPs.3–7 As shown in Table 1, these trials reported a total of 97 intrauterine pregnancies and one EP. The proportion of pregnancies that were ectopic was thus 1.02% (95% exact CI 0.02%–5.55%).

This proportion is consistent with the reported national rate of 12.4 and 19.7 per 1000 pregnancies in England and Wales and in the USA, respectively.8,9 Therefore, these trials provide no evidence to suggest that progestogen-only ECPs increase the chance that a pregnancy will be ectopic. Moreover, because ECPs are so effective at preventing pregnancy in general, they certainly reduce a woman’s absolute risk of EP.

We believe that the CSM’s advice is overcautious, as women have been using progestogen-only ECPs for many years without an increase in the incidence of EP. We agree, however, that a handful of additional cases may be more reassuring for practitioners, as the CSM suggests, and for easier access for all women who need this method of contraception.

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References

Table 1 Results of five clinical trials of levonorgestrel-only emergency contraceptive pills

<table>
<thead>
<tr>
<th>Trial</th>
<th>Known outcomes (n)</th>
<th>Pregnanacies (n)</th>
<th>Ectopic pregnancies (n)</th>
<th>Dose of levonorgestrel</th>
</tr>
</thead>
<tbody>
<tr>
<td>WHO (2002)</td>
<td>1356</td>
<td>24</td>
<td>1</td>
<td>0.75 mg in two doses 12 hours apart</td>
</tr>
<tr>
<td>WHO (2003)</td>
<td>1356</td>
<td>20</td>
<td>0</td>
<td>1.5 mg as a single dose</td>
</tr>
<tr>
<td>Arowoju et al. (2002)</td>
<td>545</td>
<td>7</td>
<td>0</td>
<td>0.75 mg in two doses 12 hours apart</td>
</tr>
<tr>
<td>Arowoju et al. (2004)</td>
<td>537</td>
<td>4</td>
<td>0</td>
<td>1.5 mg as a single dose</td>
</tr>
<tr>
<td>WHO (1998)</td>
<td>976</td>
<td>11</td>
<td>0</td>
<td>0.75 mg in two doses 12 hours apart</td>
</tr>
<tr>
<td>Wu et al. (1999)</td>
<td>643</td>
<td>20</td>
<td>0</td>
<td>0.75 mg in two doses 12 hours apart</td>
</tr>
<tr>
<td>Ho and Kwan (1993)</td>
<td>410</td>
<td>12</td>
<td>0</td>
<td>0.75 mg in two doses 12 hours apart</td>
</tr>
<tr>
<td>Total</td>
<td>5859</td>
<td>98</td>
<td>1</td>
<td>0.75 mg in two doses 12 hours apart</td>
</tr>
</tbody>
</table>


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