

BULLETIN BOARD

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 Use*² 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?

We, in Worcestershire, train pharmacists over two evenings: the first evening for pharmacists entering the scheme; the second evening for pharmacists experienced in issuing emergency contraception under PGDs. There is a sharing of experience, likes and dislikes about offering the service, how to train shop staff to be supportive, dealing with press enquiries, revisiting child protection issues, etc.

The sessions were deemed to be valuable, informative, 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 nurses trained and able to issue POEC and for easier access for all women who need this method of contraception.

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- 3 World Health Organization (WHO). Improving access to quality care in family planning. *Medical eligibility criteria for contraceptive use*. Geneva, Switzerland: WHO, 2000.

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 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 boring received wisdom, as every department that has set up nurses supplying to a Patient Group Direction will recognise!

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Ectopic pregnancy following use of progestin-only ECPs

Madam

We read with great interest the editorial about ectopic pregnancy (EP) following use of progestin-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 progestin-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 progestin-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 agree with the authors of the Editorial and with the CSM that a woman who has used progestin-only ECPs and who subsequently has clinical symptoms of EP should seek appropriate evaluation, as should any woman with such symptoms. However, no evidence exists to warrant heightened concern in users of progestin-only ECPs.

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

Trial	Known outcomes (n)	Pregnancies (n)	Ectopic pregnancies (n)	Dose of levonorgestrel
WHO (2002) ³	1356	24	1	0.75 mg in two doses 12 hours apart
WHO (2002) ³	1356	20	0	1.5 mg as a single dose
Arowojolu et al. (2002) ⁴	545	7	0	0.75 mg in two doses 12 hours apart
Arowojolu et al. (2002) ⁴	573	4	0	1.5 mg as a single dose
WHO (1998) ⁵	976	11	0	0.75 mg in two doses 12 hours apart
Wu et al. (1999) ⁶	643	20	0 ^a	0.75 mg in two doses 12 hours apart
Ho and Kwan (1993) ⁷	410	12	0	0.75 mg in two doses 12 hours apart
Total	5859	98	1	

^aPersonal communication from Shangchun Wu, 16 February 2003. WHO, World Health Organization.

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