I trust that your readers can be reassured that the CEU is committed to providing objective summaries of available evidence as a service to Faculty members. Our documented code of practice precludes any relationships with pharmaceutical companies that might represent competing interests in our product reviews. In line with established principles of evidence-based medicine, we do not make clinical practice recommendations based on assumptions, personal beliefs or inappropriate extrapolations from research data. On this basis, we stand by our published conclusions and recommendations regarding the desogestrel pill.

Gillian Penners, FRCOG, MFFP
Honorary Director, Clinical Effectiveness Unit, Faculty of Family Planning and Reproductive Care, Aberdeen Maternity Hospital, Cornhill Road, Aberdeen AB25 2ZD, UK

References

New GyneFix® introducer
Madam
We wish to share our experience with the new GyneFix® introducer. The Abacus Centre in Liverpool was the first service to offer the frameless intrauterine device, GyneFix in the UK, when it was introduced in 1997. To date we have fitted 1750 of these devices. Our audit of the first 100 insertions showed we had 11 failed insertions (of the 1000). Since the introduction of the new GyneFix introducer in our service in early 2002, we have reported no cases of failed insertion by all doctors carrying out insertions in our service. Initially we considered this to be part of the learning curve with the introducer or the device. However, when the failed insertions continued, we undertook an audit of failed GyneFix insertions from January 2003 to August 2003. During this period there were 50 attempted GyneFix insertions of which 38 were successful and 12 failed to anchor the device. In 7/8 successful insertions, there was more than one attempt to implant the GyneFix. We wasted 18 devices during the 50 attempted insertions. There was no indication that doctors with prior experience in GyneFix fitting had fewer failed insertions compared to those who had fitted fewer devices. This has raised difficulties in our counselling of women for GyneFix insertions as well as in our ability to continue to offer it as part of our contraceptive menu. We have reported these failed insertions to the manufacturer. We have heard from them that they have decreased the thickness of the tail of the inserter and they are working to reduce this problem. However, this modification is only in the GyneFix 200, which only has four beads and for which there are few published long-term data.

We will be very interested to hear from other services as to whether they are experiencing similar problems with the new GyneFix introducer.

Andrea Brockmeyer, MRCOG, DFFP
Subspecialty Trainee; State Exam Med Tubingen/Germany, Abacus Clinics for Contraception and Reproductive Health Care, Liverpool, UK

Changes to cervical cytology screening
Liquid-based cytology will now be the preferred method of examination. In this method of screening the sample is collected from the cervix in the same way, but using a special plastic broom-like device which is swept over the transitional zone five times to collect cellular material. The material is then fixed and processed using a special automated process, which results in the prepared slide looks much clearer for analysis. The number of unsatisfactory (inadequate) slides is reduced and fewer women will be referred for further examination. The frequency of screening will also be changed to a more equitable system. All women, wherever they live, are to be screened every 3 years from the age of 25–49 years and then every 5 years until the age of 64 years. Further information is available at www.nice.org.uk.

Male contraception
Health professionals may have been perplexed by reports in the media about ‘The risk-free pill for men’ (Daily Mail) or ‘Male birth control pill successfully tested’ (The Daily Telegraph). These newspapers had picked up on a report from Australia that showed no pregnancies in the partners by the end of 12 months. The men received an injection of 150 mg depot medroxyprogesterone acetate every 4 months. No serious side effects such as weight gain or hypertension were recorded in the 55 men studied. All male methods requiring sperm suppression have a long lead-in period, of course. It will be interesting to see if larger studies are as free from problems, such as mood swings or other loss of libido, as the limited previous studies of this combination of therapies. Further information on male contraception is available from www.malecontraceptives.org.

Four periods a year
Seasonal® has been approved by the Food and Drug Administration in the USA. It contains levonorgestrel and ethinyl oestradiol and is taken consecutively for 84 days, followed by seven pill-free days to produce a withdrawal bleed. Trials showed a similar effectiveness to conventional combined oral contraceptives. Some of the comment surrounding this alternative has suggested that it is healthier to avoid menstrual loss, a statement that cannot be backed by evidence at present. Making Seasonal available will expand women’s contraceptive options and increase convenience for some. This advance should not be undermined, however, by over-promising and over-promotion of its physiological benefits. More information is available from www.womenshealthnetwork.org.

Reviewed by Gill Wakesley, MD, MFFP
Visiting Professor in Primary Care Development, Staffordshire University and Freelance General Practitioner, Whitchurch, Shropshire, UK and P S Arumukam, MRCOG
Specialist Registrar in Obstetrics and Gynaecology, Rosie Maternity Hospital, Cambridge, UK

Letters / News Roundup

NEWS ROUNDUP

A new IT solution for sexual health? Information technology (IT) has been promoted as a panacea for all ills and sexual health is no exception. The technological boom is here to lend a helping hand to deal with the current sexual health: testing times for treatments. (April 2003). Desogestrel-only pill (Cerazette). J Fam Plann Reprod Health Care 2003; 29(3): 127–135.

New GyneFix® introducer
Madam
We wish to share our experience with the new GyneFix® introducer. The Abacus Centre in Liverpool was the first service to offer the frameless intrauterine device, GyneFix in the UK, when it was introduced in 1997. To date we have fitted 1750 of these devices. Our audit of the first 100 insertions showed we had 11 failed insertions (of the 1000). Since the introduction of the new GyneFix introducer in our service in early 2002, we have reported no cases of failed insertion by all doctors carrying out insertions in our service. Initially we considered this to be part of the learning curve with the introducer or the device. However, when the failed insertions continued, we undertook an audit of failed GyneFix insertions from January 2003 to August 2003. During this period there were 50 attempted GyneFix insertions of which 38 were successful and 12 failed to anchor the device. In 7/8 successful insertions, there was more than one attempt to implant the GyneFix. We wasted 18 devices during the 50 attempted insertions. There was no indication that doctors with prior experience in GyneFix fitting had fewer failed insertions compared to those who had fitted fewer devices. This has raised difficulties in our counselling of women for GyneFix insertions as well as in our ability to continue to offer it as part of our contraceptive menu. We have reported these failed insertions to the manufacturer. We have heard from them that they have decreased the thickness of the tail of the inserter and they are working to reduce this problem. However, this modification is only in the GyneFix 200, which only has four beads and for which there are few published long-term data.

We will be very interested to hear from other services as to whether they are experiencing similar problems with the new GyneFix introducer.

Andrea Brockmeyer, MRCOG, DFFP
Subspecialty Trainee; State Exam Med Tubingen/Germany, Abacus Clinics for Contraception and Reproductive Health Care, Liverpool, UK

Changes to cervical cytology screening
Liquid-based cytology will now be the preferred method of examination. In this method of screening the sample is collected from the cervix in the same way, but using a special plastic broom-like device which is swept over the transitional zone five times to collect cellular material. The material is then fixed and processed using a special automated process, which results in the prepared slide looks much clearer for analysis. The number of unsatisfactory (inadequate) slides is reduced and fewer women will be referred for further examination. The frequency of screening will also be changed to a more equitable system. All women, wherever they live, are to be screened every 3 years from the age of 25–49 years and then every 5 years until the age of 64 years. Further information is available at www.nice.org.uk.

Male contraception
Health professionals may have been perplexed by reports in the media about ‘The risk-free pill for men’ (Daily Mail) or ‘Male birth control pill successfully tested’ (The Daily Telegraph). These newspapers had picked up on a report from Australia that showed no pregnancies in the partners by the end of 12 months. The men received an injection of 150 mg depot medroxyprogesterone acetate every 4 months. No serious side effects such as weight gain or hypertension were recorded in the 55 men studied. All male methods requiring sperm suppression have a long lead-in period, of course. It will be interesting to see if larger studies are as free from problems, such as mood swings or other loss of libido, as the limited previous studies of this combination of therapies. Further information on male contraception is available from www.malecontraceptives.org.

Four periods a year
Seasonal® has been approved by the Food and Drug Administration in the USA. It contains levonorgestrel and ethinyl oestradiol and is taken consecutively for 84 days, followed by seven pill-free days to produce a withdrawal bleed. Trials showed a similar effectiveness to conventional combined oral contraceptives. Some of the comment surrounding this alternative has suggested that it is healthier to avoid menstrual loss, a statement that cannot be backed by evidence at present. Making Seasonal available will expand women’s contraceptive options and increase convenience for some. This advance should not be undermined, however, by over-promising and over-promotion of its physiological benefits. More information is available from www.womenshealthnetwork.org.

Reviewed by Gill Wakesley, MD, MFFP
Visiting Professor in Primary Care Development, Staffordshire University and Freelance General Practitioner, Whitchurch, Shropshire, UK and P S Arumukam, MRCOG
Specialist Registrar in Obstetrics and Gynaecology, Rosie Maternity Hospital, Cambridge, UK

Journal of Family Planning and Reproductive Health Care 2004; 30(1)