
There are more than 80 types of human papilloma virus (HPV) and approximately 30 strains are associated with genital infection. Several of the strains can be associated with cervical neoplasia. Evidence is accumulating to show that detection of specific HPV types could help detect those at most risk of cervical neoplasia disease progression.

This study looked at the diversity of HPV infection and its association with cervical neoplasia. It used 3444 randomly selected samples, which were residual from liquid-based cytology samples. Its aim was to investigate the overall prevalence of HPV, the type specific prevalence and the number with multiple infections. This was then compared with the cytological assessment for neoplasia.

Approximately 10% of the samples showed some HPV infection and this may influence the addition of grade dyskaryosis, respectively. HPV infection was detected in 20% of samples, and 77% of these showed a high-risk type of HPV. Surprisingly, 42% of the positive samples from under-25-year-olds showed a high-risk type of HPV. The probability of a woman discontinuing a contraceptive method when used in the USA in 2003; Contraception 68: 185–191

This is another report derived from the data acquired by the Family Planning Association (Fpa) Study. Readers will remember that the study recruited about 17,000 married women between the ages of 25 and 39 years, from 17 family planning clinics between 1968 and 1974, who used oral contraceptives (OCs), a diaphragm or an intrauterine device. By the end of December 2000, 889 women had died.

The study found no overall increased risk of death from all causes among women who used OCs (regardless of duration of pill use) compared with women in the study who had never used OCs. Although the data suggested that the overall risk of death from all causes among OC users was lower than among non-users, this did not quite reach statistical significance.

In comparison with non-smokers, light smokers showed a slight increase in death from all causes of around 25%, and heavy smokers (women who smoked more than 15 cigarettes a day) showed more than a doubling of death risk from all causes.

Even in women over 55 years, the harmful effects of smoking were already apparent.

The authors concluded that Yuzpe regime EC can be used on the fourth or fifth day after UPSI. The users were put into two groups: pregnancy rates were respectively 0.8% and 1.8%. The authors concluded that POEC could be given up to 120 hours after UPSI. The second paper was the World Health Organization (WHO) study previously reviewed in the Journal Club section of this Journal.2 This is a study of 4136 women requesting EC who were randomly given either mifepristone or levonorgestrel up to 120 hours after UPSI. For the levonorgestrel group, the pregnancy rates on Days 4 and 5 after UPSI were 1.1% and 4.8%, respectively. The mifepristone rates on Days 4 and 5, respectively, were 1.0% and 3.6%.

The study did not show any relationship between length of vaginal bleeding and days after bleeding stopped and death from breast cancer mortality. The figures need to be considered together with the knowledge that this study did not recruit young women starting OCs before their first full-term pregnancy and that only 16% of the total number of women who died had recent or current exposure to OCs. A large number of other causes of death were examined and their relationship to smoking and OC use. This is useful information if you need to discuss specific risks with an individual woman.

The Oxford Ipa Study is one of only three large-scale studies of long-term OC safety. It provides valuable data on the long-term effects of contraceptive use as well as morbidity and mortality among women of childbearing age. It does have some limitations. Long-term studies are subject to loss to follow-up and numbers dwindle. The numbers of deaths from any cause in this age group is (thankfully) small. Most of the OCs used in the 1970s and early 1980s contained a single estrogen. It is unclear whether the findings can be extrapolated to the pills in use currently. Also, some effects of OCs (e.g. on cardiovascular disease or breast cancer) have been shown to apply mainly to current or very recent users. OCs are already stopped when serious illness occurs, but death may not occur for many years. The analysis of the effects of smoking only considered the amount recorded at recruitment: 38% of the light smokers and 14% were heavy smokers.

The authors warn that the small numbers of women given delayed treatments in this trial makes our estimation very imprecise’. The third paper3 compared 675 women who had used Yuzpe regime EC within 72 hours with 111 who had Yuzpe regime EC between 72 and 120 hours after UPSI. The authors suggested that the best limit may turn out to be 96 hours. Meanwhile, the official Faculty of Family Planning and Reproductive Health Care advice is that the limit should be 72 hours.4

References
1 O’Brien. Journal Club review.
4 Review by Gill Wakeley, MD, MFFP
Reviewed by Gill Wakeley, MD, MFFP
Visiting Professor in Primary Care Development, Stafford University and Freelance GP and Writer, Abergavenny, UK


This paper is the fourth in recent years that has suggested that hormonal emergency contraception (EC) can be used on the fourth or fifth day after unprotected sexual intercourse (UPSI). This paper cites an imaginary woman who reported 4 days after UPSI. The author recommends that progestagen only emergency contraception (POEC) be prescribed. This is justified by reference to clinical studies,2 in which hormonal EC on the fourth and fifth days appeared to be effective. It will be relevant to look to the other two papers.

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1 O’Brien. Journal Club review.

Reviewed by Michael Cox, FRCOG, MFFP
Consultant Obstetrician and Gynaecologist (Retired), Nuneaton, UK


This paper analyses the cost-effectiveness of a contraceptive method when used in the USA in relation to prevention of pregnancy and cost saving of a method. It does not include all methods, for example, implants, and excludes vasectomy costs.

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