
There are more than 80 types of human papillomavirus (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 persistent HPV 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 degree of neoplastic abnormality. HPV 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 were HPV-positive.

The results also showed that with increasing severity of dyskaryosis on cervical sample there was an increasing prevalence of HPV virus. Infection with multiple HPV types were found in 3.4% of negative sample and in 33.3%, 41.8% and 52.5% of positive samples, respectively. The authors warned that the small numbers with wide confidence intervals. Although some women who took OCs and did not smoke, or only smoked lightly, showed no increased mortality from ischaemic heart disease, women who took OCs and smoked heavily showed a slightly increased death rate. The study did not show any relationship between length of pill use and the incidence of cervical cancer or between smoking and breast cancer mortality. The authors concluded that 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 current or recent exposure to OCs. A large number of other causes of death were examined, not their relationship to smoking and OC use.

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 selection bias following contraception use. 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, and effects may be magnified for women who have smoked heavily. The authors warn that the small numbers of women given delayed treatments in this trial makes our estimation very imprecise. This paper analyses the cost-effectiveness of a hypothetical calculation as we all know women who fall outside the standard criteria as described above. Until the variables set by all contraceptive users are fully addressed it is likely that any calculations can only give a rough estimate of the cost-effectiveness of a particular method.


This is another report derived from the data acquired in the Family Planning Association (Ipa) 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 was slightly lower among OC users than among non-users, this did not quite reach statistical significance.

In contrast with non-smokers, light smokers showed a small 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 who used OCs, the harmful effects of smoking were already apparent.

The study provided no surprises in reporting that in users of OCs compared with non-users, there was a decrease in mortality from uterine and ovarian cancer. Overall, OC use did not change the rates for perfect and typical users. The 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 paper1 was the World Health Organization (WHO) study reviewed in the Journal in April 2004. The pregnancy rates on Days 4 and 5 after UPSI were 1.1% and 4.8%, respectively. The mifepristone pregnancy rates on Days 4 and 5, respectively, were 1.0% and 1.1% and 4.8%, respectively. The authors warn that “the small numbers of women given delayed treatments in this trial makes our estimation very imprecise”.

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 selection bias following contraception use. 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, and effects may be magnified for women who have smoked heavily. The authors warn that the small numbers of women given delayed treatments in this trial makes our estimation very imprecise. This is the fourth paper in recent years that has suggested that hormonal emergency contraception (EC) can be used on the fourth or fifth day after unprotected sexual intercourse (UPS1). This paper cites an imaginary woman who reported 4 days after UPSI. The author recommends that progesterone (POEC) be prescribed. This is justified by reference to clinical studies1,2 in which hormonal EC on the fourth and fifth days appeared to be effective. It will be relevant to compare to the other three papers. The first paper1 described POEC given to 131 women before 72 hours after UPSI compared to POEC given to 169 women between 72 and 120 hours after UPSI. The pregnancy rates were respectively 0.8% and 1.8%.

This paper provides evidence in favour of extending the 72-hour limit. Although numbers are limited it is interesting that the highest pregnancy rates in the WHO study did not occur till the fifth day with low rates of effectiveness suggesting 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.2

References


Emergency contraception...