
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 persistent HPV infection 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 prevalent 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 40.4% of samples with borderline, mild or high-grade dyskaryosis, respectively. HPV infection with a single type showed a very similar picture. This was then compared with the cytological study in progress and this may influence the addition of HPV testing to the cervical screening programme. The result of current pilot studies looking for HPV in under-25-year-olds may also help with this decision.

Reviewed by Laura Patterson, MRCGP, MFFP
GP Neonatal Lead, Associate Specialist in Family Planning, Swindon, UK


This paper analyses the cost-effectiveness of a contraceptive pill which used the US in a related study as a prevention of pregnancy and cost saving of a method. It does not include all methods, for example, implants, and excludes vasectomy costs.

The probability of a woman discontinuing a method or complications requiring medical treatment was estimated from USA national data and surveys. The model used made some assumptions about how a woman uses contraception. The study only included parous women, and it assumed that if a patient discontinued a method she would start another. It was assumed that if a woman giving birth a woman would start a method within 2 months and that, when calculating the cost for barrier methods, it was assumed that a woman had 83 acts of sexual intercourse a year.

The conclusions drawn from the calculations were that intrauterine devices or the intrauterine system are the most cost-effective methods to use. The way in which the calculations were carried out was well illustrated and could easily be adapted for the UK. It would be interesting to see if by including implant and vasectomy for the UK figures a subsequent study would come out with a different conclusion.

It has to remembered that this is purely 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.

Reviewed by Judy Murty, DRCOG, MFFP
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This is another report derived from the data acquired from 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 comparison with non-smokers, light smokers smokers showed a slightly increased death rate from death from all causes of around 2.5%, 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 smoked 5–14 cigarettes a day, 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. This is an important study. The longitudinal study is in progress and this may influence the addition of HPV testing to the cervical screening programme. The result of current pilot studies looking for HPV in under-25-year-olds may also help with this decision.

Reviewed by Helen Ramsay, DRCOG
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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 progestin (a POEC) be prescribed. This is justified by reference to clinical studies in which hormonal EC on the fourth and fifth days appeared to be effective. It will be relevant to POEC to the other three papers. The first paper described POEC given to 131 women between 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%. 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. This was 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 5.3%. The author states that “the small numbers of women given delayed treatments in this trial makes our estimation very imprecise”. The third paper compared 675 women who had Yuzpe regime EC between 72 hours with 111 who had Yuzpe regime EC between 72 and 120 hours after UPSI. The users were put into two groups: perfect users and typical users. The pregnancy rate on perfect and typical users was respectively 0.7% and 1.8%. The authors concluded that Yuzpe regime EC could be given up to 120 hours after UPSI especially if an IUD was contraindicated. The authors warn that “the small numbers of women given delayed treatments in this trial makes our estimation very imprecise”. The Yuzpe regime EC was the World Health Organization (WHO) study previously reviewed in the Journal Club section of this Journal. This was 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 5.3%. The author states that “the small numbers of women given delayed treatments in this trial makes our estimation very imprecise”. The Yuzpe regime EC was the World Health Organization (WHO) study previously reviewed in the Journal Club section of this Journal. This was 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 5.3%. The author states that “the small numbers of women given delayed treatments in this trial makes our estimation very imprecise”. The Yuzpe regime EC was the World Health Organization (WHO) study previously reviewed in the Journal Club section of this Journal. This was 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 5.3%. The author states that “the small numbers of women given delayed treatments in this trial makes our estimation very imprecise”. The Yuzpe regime EC was the World Health Organization (WHO) study previously reviewed in the Journal Club section of this Journal. This was 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 5.3%. The author states that “the small numbers of women given delayed treatments in this trial makes our estimation very imprecise”. The Yuzpe regime EC was the World Health Organization (WHO) study previously reviewed in the Journal Club section of this Journal. This was 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 5.3%. The author states that “the small numbers of women given delayed treatments in this trial makes our estimation very imprecise”.

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