methods avoiding first-pass hepatic metabolism. The value and safety of 3-monthly intramuscular DMPA have been ascertained, and an annual depot contraceptive with combined oestrogen and progestogen is also available. Recently, a male long-acting delivery system consisting of intramuscular DMPA and testosterone implant has been found to have a high contraceptive efficacy, which is even superior to the male condom. Besides providing excellent contraception, the levonorgestrel-releasing intrauterine system is licensed for treating menorrhagia and has great potential for hormone replacement therapy. Progestogen-releasing subdermal implants have a very high use-effectiveness, whereas a single dose of levonorgestrel given within 5 days of unprotected intercourse constitutes a recognised regimen for emergency contraception.

COCs continue to be used off-label for modifying the length of the menstrual cycle including continuous use of more than one cycle of 21 pills: bicycling for two cycles and tricycling for three cycles. The latest regimen consists of an annual pattern with four seasonal withdrawal bleeds through 91-day cycles: four continuous packs, each of 21 pills of COCs, for 34 days are followed by an interval of seven pill-free days.

Implications for current practice

Newer products should be given a chance to prove themselves, as any risk of relying on expectations from their biochemical and pharmacological profiles can be identified through clinical trials and postmarketing surveillance. Individuals seem to be more interested in the positive aspects of health and the avoidance of side effects, such as acne, bloating and perceived weight gain, as compared to concerns regarding an apparent small increase of mortality risk from thromboembolism and cancer. Therefore, it seems reasonable to seek products that address morbidity issues pertaining to contraceptive methods. Hormonal replacement therapy for the prevention of postmenopausal coronary heart disease was popular until recently when it was associated with the opposite effect: the metabolic effects of the progestogen component being incriminated, there is current interest in regimens using newer progestogens administered through alternative delivery systems. Whereas the ramifications of new products and procedures are not always clear, clinicians have a duty to apply sound research findings in their professional practice even in defiance of official guidelines, pronouncements from drug regulatory authorities and product labelling from manufacturers. In selecting products for primary care and public health programmes, cost considerations should permeate a culture of maximising benefits at the community level whilst recognising the need for certain products to be available beyond the primary care level for medical conditions, such as menorrhagia, that interface with contraception.

The search for new compounds and subsequent development of related formulations are expected to enable individuals to exert the right to choose the most appropriate product to meet their needs. With advances in molecular biology, progestogens have recently been defined in terms of their affinity for binding with progesterone receptors. Applications of selective progesterone receptor modulators could drastically alter the future use of contraceptive products containing progestogens whose original recognised role in protecting gestation has resurfaced lately, albeit beyond the first trimester, for the prevention of preterm labour.

References