Evidence-based medicine and guidelines

Madam

It feels necessary to join the discussion about evidence-based medicine (EBM) and guidelines. I am dismayed by the constant negative attitude towards new contraceptives that are available.

I do not believe (serious safety issues aside) that contraceptives should be viewed in entirely the same light as drugs used for a medicinal purpose; in the latter some minor adverse side effects are tolerated provided the overall risk/benefit balance is acceptable for the condition being treated. With contraception, both efficacy and minor side effects are equally important. Indeed, for some women, the balance is reversed with a poorer efficacy being tolerated in favour of lesser or more acceptable side effects.

The proponents of EBM have lost sight of the fact that most of what we do in family planning is not based on evidence – it would now be considered good evidence, and that it is reasonable to make certain assumptions. Last year the Clinical Effectiveness Unit’s Product Review of Cerazette stated: “an evidence-based recommendation cannot be made that the desogestrel pill is different from other POPs in terms of efficacy, …”, while the Drug and Therapeutics Bulletin went further: “...there is insufficient evidence on whether it is a more effective contraceptive than other POPs, and … we believe the company’s claim that Cerazette has the ‘efficacy of a combined pill’ is unsubstantiated and should be withdrawn”. Less than a year later, the product licence for Cerazette has been officially altered to allow a 12-hour pill-taking leeway – the same as for the combined pill. To most of us, this had been obvious from the start: while acknowledging a lack of good evidence, why could those writing the product reviews not have been less scathing, more willing to use a little common sense? Similar attacks have been made on both Evra and Yasmin, which should be welcomed as providing alternatives for women who may not have found a method that suits them.

Choice is extremely important: a woman may wish to use a product simply because her friend is happy with it. This may not be evidence-based, but if it will improve her compliance then it may be less expensive than paying for her termination of pregnancy. Most modern contraceptives are very good: should we only have the one and tell women there is so little difference between them that it will do? Perhaps the Drug and Therapeutics Bulletin should learn from how people use its sister publication Which?

When I want to buy a washing machine, I might not choose their evidence-based top product if it does not wash my clothes, however well it washes my clothes.

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References

Role of nurses

Madam

The Nursing Focus article by Pam Campbell in the July issue of the Journal raised the important issue of the enhanced nurse role, which is not being fully utilised in many areas. The major barriers to implementing this role for nurses are not based on what would now be considered good evidence, and that it is reasonable to make certain assumptions.

It is a fact that some nurses do not wish to expand the one and tell women there is so little difference between them that it will do. The chances of finding a small portion of a IUD fragment is not based. The comments regarding nationally approved standards for training echo the thoughts in my article. The development of a portfolio of competence measured against these standards would be an excellent move forward. Perhaps the sexual health leads within strategic health authorities could be asked to take these ideas forward for national debate and co-ordination with the Nursing and Midwifery Council.

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Reference

Missing IUD fragment

Madam

The case report of Nadir et al. recommends that if a small fragment of an intrauterine contraceptive device (IUD) is found to be missing and cannot be retrieved by hysteroscopy or laparoscopy then laparotomy is necessary. This advice is neither pragmatic nor evidence based. The chances of finding a small portion of an IUD at laparotomy are remote and would require an expensive midline incision. The subsequent morbidity (adhesion formation, subucate obstruction, etc) considerably outweighs a theoretical risk of intestinal perforation, which in the unlikely event of it occurring, is not likely to cause a major degree of peritonitis.

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Reference