Evidence-based medicine and guidelines

Madam

I feel it 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 hardly evidence-based. 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 that 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… we believe the company’s claim that Cerazette has the “efficacy of a combined pill” is unsubstantiated and should be withdrawn’.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 Yaumin®, 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 take on extra responsibilities. However, the comments regarding nationally agreed PGDs will allow terminated when it is needed, and only then. Without the necessary freedom from drug company pressure, some women may not wish to take on extra responsibilities. However, the introduction of the Knowledge and Skills Framework for Change will differentiate between these staff and others who are committed to increasing their clinical skills.

References


Letters

Role of nurses

Madam

The Nursing Focus article by Pam Campbell in the July 2004 edition of the Journal raised the important issue of the enhanced nurse role, which is not being addressed sufficiently in many areas. Furthermore, the barriers to implementing this role for nurses are not well recognised. For instance, in the NHS Pay System the role of nurses is not based on evidence that 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 Yaumin®, which should be welcomed as providing alternatives for women who may not have found a method that suits them.

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References


Missing IUD fragment

Madam

The case report of Nadger et al.1 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 extensive midline incision. The subsequent morbidity (adhesion formation, subacute obstruction, etc) considerably outweighs a theoretical risk of intestinal perforation, which even in the unlikely event of it occurring, is not likely to cause a major degree of peritonitis.

References

