BULLETINBOARD

Letters/News Roundup

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HIV risk taking

A study using computer-assisted self-interviews to explore the risk taking in young women aged 18–25 years old who attend a sexually transmitted infection (STI) clinic in Middlesbrough, UK, was reported in the journal J Fam Plann Reprod Health Care. The study found that young women who had sex with men who identified themselves as gay or bisexual were more likely to engage in HIV-risk taking behaviors such as using or having used oral contraceptives. So beware, more than half of the women surveyed were not sexually active but suffered from severe premenstrual tension that had not responded to life-style and dietary measures. They were treated with antidepressants and physical symptoms (breast enlargement/tenderness and bloating). All symptoms responded within the first 3 months of treatment with Cerazette. The patient had an initial 3-day bleed followed by amenorrhea. She remains amenorrheic 1 year later with total clearance of her PMS. I would be interested in readers’ experience of the use of Cerazette for PMS and whether a therapeutic role has been observed in women who continue to menstruate.

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References

1. Kabrowski B, Schneider HP. Removal of an occult intrauterine contraceptive device (IUD) fragment is not found on diagnostic hysteroscopy or laparoscopy. Due to lack of conclusive data, currently, the risks of extensive surgery certainly outweigh the theoretical risk of intestinal perforation in the situations outlined above. However, each case should be assessed individually and involve full discussion of the merits of conservatively managing against surgical exploration. The wishes of the woman involved should also be considered in the consultation process.

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Vaginal rings for contraception

Vaginal rings are made of soft, flexible, silicone rubber and release hormones that slowly disseminate and are absorbed from the vagina. Depending on the type of ring used, prolonged release hormone may occur from 3 weeks to 1 year. The advantages of the vaginal ring method are that it is user-controlled, does not interfere with intercourse, does not require daily intake of a pill, and allows continuous delivery of a low dose of steroids. The Population Council has developed a progesterone-releasing ring, which is currently on the market in Chile and Peru for contraception in breastfeeding women. Trials of a contraceptive ring releasing very low doses of the potent progesterin, Norelgestromin® for 6 to 12 months are also under way. Other ring formulations, however, contain hormone combinations that provide excellent contraceptive efficacy with few side effects and good control of menstrual bleeding. The Food and Drug Administration in the USA has recently approved a monthly ring releasing etonogestrel and ethinylestradiol. The Population Council is developing a 1-year contraceptive ring releasing low doses of Norethisterone and ethinylestradiol. Combination rings are associated with very low pregnancy rates and side effects consistent with those of combined oral contraceptives.


The final cut

One in five women in Britain uses sterilisation as their method of contraception. A survey of 12 000 women in Britain, France, Germany, Italy and Spain indicated that the average for numbers of people with gonorrhoea, genital warts and herpes were recorded. Both the chairman of the British Medical Association and the president of the British Association of Sexual Health and HIV (BASHH) called for better resources to provide prompt testing and treatment. The present long waiting lists at GUM clinics increases the risks of infections being spread while people wait for testing. Attempts to transfer any of this burden to primary care and community clinics are doomed to failure unless additional resources, trained health professionals and time are available.

 calls for resources for GUM

The public health agency published the most recent figures for sexually transmitted infections (STIs) in July. The report pointed out that new cases of STIs continue to rise and unsafe sexual practices contributed to this. More people are coming forward for testing contributed to the increases in numbers identified but this puts an enormous pressure on genitourinary medicine (GUM) clinics. Some successes such as falls in the numbers of people with gonorrhoea, genital warts and herpes were recorded. Both the chairman of the British Medical Association and the president of the British Association of Sexual Health and HIV (BASHH) called for better resources to provide prompt testing and treatment. The present long waiting lists at GUM clinics increases the risks of infections being spread while people wait for testing. Attempts to transfer any of this burden to primary care and community clinics are doomed to failure unless additional resources, trained health professionals and time are available.

Replies

Madam,

I agree with the point made by Dr Peter Bowen-Simpkins that the recommendation made in our case report is that if a small fragment of an intrauterine contraceptive device (IUD) is found to be missing and cannot be retrieved hysteroscopically or laparoscopically, a laparotomy should be done, is not evidence-based practice.

Fragmentation of an IUD frame is a rare complication. The possibility of the fragment perforating the uterine muscle, leading to perforation of intestine, although remote, has been suggested by Kabrowski et al2 in their case report.

I also agree that the case report does not justify the recommendation of a laparotomy as a routine practice in situations where the missing IUD fragment is not found on diagnostic hysteroscopy or laparoscopy. Due to lack of conclusive data, currently, the risks of extensive surgery certainly outweigh the theoretical risk of intestinal perforation in the situations outlined above. However, each case should be assessed individually and involve full discussion of the merits of conservatively managing against surgical exploration. The wishes of the woman involved should also be considered in the consultation process.

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References


Cerazette for premenstrual tension

Madam

I have used Cerazette® to manage a patient who was not sexually active but suffered from severe premenstrual tension that had not responded to life-style and dietary measures. They were treated with antidepressants and physical symptoms (breast enlargement/tenderness and bloating). All symptoms responded within the first 3 months of treatment with Cerazette. The patient had an initial 3-day bleed followed by amenorrhea. She remains amenorrheic 1 year later with total clearance of her PMS. I would be interested in readers’ experience of the use of Cerazette for PMS and whether a therapeutic role has been observed in women who continue to menstruate.

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contains updated content and illustrations and an expanded description of ligation and excision with fascial interposition, a method that has been shown to significantly improve the procedure’s effectiveness.

Founded in 1943, EngenderHealth is a non-profit organization that has been working internationally for more than 30 years to support and strengthen reproductive health services for women and men worldwide. Since its inception, its work has improved the health of more than 100 million individuals in 90 countries. Further information about the agency and copies of the guides are available at http://www.engenderhealth.org.

New prescribing information for the desogestrel oral contraceptive

Following new evidence, the prescribing information for the desogestrel oral contraceptive (Cerazette®) has been changed. One of the disadvantages of progestogen-only pills (POPs) compared with combined oral contraceptives (COCs) has been the need to take it at the same time each day, with only 3 hours ‘forgetting time’. Now a study has confirmed that forgetting this desogestrel pill for 12 hours is not related to ovulation. In a study of women with confirmed previous ovulation, 103 women took Cerazette for 56 days and 12 hours late on three scheduled occasions. Only one ovulated (measured by alternate day progesterone P levels). That episode was not temporally related to late taking of the pill. The minimum time to post-treatment ovulation was 7 days with an average of 17.2 days from the last tablet taken to ovulation. So now you can give people taking the desogestrel POP the same information as you have done for COCs – if the missed pill is remembered and taken within 12 hours, no additional contraceptive precautions are required.

Reference


Anaphylactic shock and DMPA

Depot medroxyprogesterone acetate (DMPA) is thought to be very safe. Occasionally serious and potentially life-threatening adverse effects can occur. This case study reports a 40-year-old woman who went into anaphylactic shock after receiving 150 mg DMPA intramuscularly. She was not taking any other medication, and there was no history of allergy to food or cosmetics. She responded fully to immediate resuscitation. A repeat episode occurred when she received another dose 12 weeks later (I would not have risked it!). Life-threatening adverse effects can occur with administration of any medication and clinicians should be prepared for such an eventuality.

Reference


Condom express

The Swedish Organisation for Sexual Education has launched a service to provide emergency condoms to those in desperate need! Using the same Chao-San Express, the organisation will have four cars loaded with condoms patrolling the streets of the capital, Stockholm, along with a pair of vehicles each in Goteborg and Malmoe, Sweden’s second and third largest cities, respectively. The express will deliver a pack of 10 condoms for slightly less than is charged at a state-owned pharmacy. The organisation hopes to ‘reach young people with a humorous twinkle in their eye’. They hope that the contraceptive will be seen as a fun sex accessory and not just as a way to protect against STIs. The initiative follows similar increases in STIs to those seen in the UK. Further information is available at http://ppfnet.ipf.org/pub/PPF_News/NewsDe tails.asp?ID=3503.

Collated and reported by Gill Wakley, MD, MFFP
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Epidemiology 2004; 15: 21–27

This interesting study looks at the relationship between stress and infertility, and whether higher stress levels are related to low sperm counts. A total of 430 Danish couples who were trying to become pregnant for the first time were followed prospectively. Initially the clients filled out a general health questionnaire and had a blood sample taken for measuring hormone, follicle-stimulating hormone, inhibin B, testosterone or oestradiol. The men also collected a semen sample for assessing sperm concentration and motility showed increased. However, the median values of semen volume, sperm concentration and motility showed no significant difference in the various categories of their general health questionnaire scores. Neither was there any effect on the hormone levels. This would seem to suggest that day-to-day stress is not a strong determinant of semen quality, but that stress may have an effect on fecundity.

Reviewed by Laura Patterson, MBCCP, DFFP
GP Non-Principal and Associate Specialist in Family Planning, Swindon, UK

How is the high vaginal swab used to diagnose vaginal discharge in primary care and how do GPs’ expectations of the test match the tests performed by their microbiology services?


This paper cannot be regarded as a reliable guide to opinion as the researchers only obtained a response from 26% of the 2146 general practitioners (GPs) and 22 laboratories in the North Thames area. A postal questionnaire asked GPs how they would manage a young woman with vaginal discharge and what information they would like on the laboratory report. The questionnaire for the laboratories asked how they processed and reported on a high vaginal swab (HVS). Most of the GPs who replied (78%) said that they would like to have a diagnosis suggested, and 74% would have liked the laboratory to suggest treatment. The majority of the 14 laboratories that replied did not meet their wishes. The diagnosis was given in 43% and a treatment advised in only 14% of cases. Perhaps the GPs and the laboratories should talk to each other to determine each other’s needs? This paper might make other areas look at what GPs and laboratories expect from each other and, if there is a similar mismatch, find ways of rectifying it.

Reviewed by Gill Wakley, MD, MFFP
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Pregnancies that result in a birth are known to reduce a woman’s risk of breast cancer, but the effect of pregnancies that end as an abortion is less clear. Evidence from retrospective studies has been difficult to interpret because women have a tendency to under-report both spontaneous and, particularly, induced abortion, whereas women diagnosed with breast cancer may be more likely to disclose this information.

The authors of this paper reviewed worldwide evidence and analysed the results from prospective and retrospective studies separately. Among women with a prospective record of having had one or more induced

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