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.

References

Condom express

The Swedish Organisation for Sexual Education has launched a service to provide emergency condoms to those in desperate need! Using the name Cho-San Express, the organisation will

News Roundup/Journal Club


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 luteinising hormone, follicle-stimulating hormone, inhibin B, testosterone or oestradiol. The men also collected a semen sample at the beginning and each month during the 6-month follow-up. A shorter version of the general health questionnaire was completed each month following. The pregnancy rate was 14% in those with the highest scores for stress and 18% for those with the lowest scores. The odds for pregnancy per cycle were reduced significantly as the stress score increased. However, the median values of semen volume, sperm concentration and motility showed no significant difference in the various groups compared to their general health questionnaire scores. Neither was there any effect on the hormone levels. This would seem to suggest that daily stress is not a strong determinant of semen quality, but that stress may have an effect on fecundity.

Reviewed by Laura Patterson, MRCP, 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? Noble H, Escourt C, Ison C, et al. Sex Trans Infect 2004; 80: 204–206

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 have liked 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
Visiting Professor in Primary Care Development, Staffordshire University and Freelance General Practitioner, Writer and Lecturer, Abergavenny, UK


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 abortions...
Effects of conjugated equine estrogen in postmenopausal women with hysterectomy. The Women’s Health Initiative Randomised Controlled Trial. JAMA 2004; 291: 1701–1712

This study was one of two parallel, randomised, double-blind, placebo-controlled trials designed to test the effects of this type of hormone replacement therapy (HRT) on chronic disease. The National Heart, Lung and Blood Institute in the USA set the study up 13 years ago. The oestrogen plus progestogen arm of the trial was halted in July 2002 due to increased risk of coronary heart disease, thromboembolic disease and breast cancer. This arm of the trial compared use of oestrogen only HRT (conjugated equine oestrogen) with placebo in nearly 11,000 women aged 50–79 years. The study was stopped a year before its scheduled conclusion, even though no predefined boundaries had been crossed. There was also a high degree of non-compliance: 50% by the seventh year. The study provides us with some important information. The treatment group had a 39% increased risk of stroke compared to the non-treatment group (44 vs 32 per 10,000 person-years). Contributing factors may have been the small but persistent increase in blood pressure and the known effect of oestrogen on increasing the risk of thrombosis. There was a reduction in low-density lipoproteins (LDLs) and an increase in high-density lipoproteins (HDLs) but no impact on coronary heart disease incidence. Oestrogen reduced the risk of fractures by 30% to 39% (11 vs 17 per 10,000 person-years) in the treatment group. They reported a lower rate of breast cancer in the treatment group compared to placebo. This particular result is contrary to the oestrogen plus progestrogen arm of the Women’s Health Initiative (WHI) trial and clearly needs further investigation. The small numbers may have confounded the results. Two components of the WHI on the effects of a low-fat eating pattern, and the effects of calcium and vitamin D supplements are still awaiting publication. For the present time, this study contributes further weight to the advice that HRT should be used for short-term relief of vasomotor symptoms only.

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


This is a community intervention study designed to determine whether offering advanced supplies of emergency contraception (EC) to large numbers of women influenced the abortion rates. In one area of Scotland women between 16 and 29 years were targeted through health services to be allowed to take home five courses of EC to keep at home for use when needed. There were 85,000 women in the target age group of whom 17,800 took a supply of EC home. Some 45% of this group took EC following unprotected intercourse, and in 30% this was the first time they had high uptake of contraception in the area but numbers are not given. The results of the intervention did not reduce the abortion rate when compared with other areas of Scotland with no intervention.

In their discussion the authors did not emphasise that the EC used was Schering PC4 which is now not available. Levonelle® is now prescribed as it has been shown to be more effective but by how much is debatable. If the area targeted had a high uptake of contraception use then women probably were not aware of their pregnancy risks when using other methods so did not use EC when necessary. This study shows that no matter what we do as clinicians, we cannot predict what contraceptive users will do and how competently they can recognise when they are at risk of pregnancy.

The study leaves concerns that sexually active young people are given messages that EC is available if they have pregnancy risk but this study may indicate that by making EC readily available this still will not impact on the abortion figures. Abortion figures will only reduce when the sexually active population are willing to use more effective long-term methods of contraception where EC is rarely needed.

Reviewed by Judy Murty, DRCOG MFPI SCMO, Contraceptive and Sexual Health Services, Leeds, UK

BOOK REVIEWS


This highly readable book tells the story of the X chromosome from Aristotle’s musings on gender difference right through to a modern understanding of the genetics of the X chromosome. The author’s engaging style makes modern genetics accessible both to the complete layperson and to those of us for whom preclinical genetics are a hazy memory. Bainbridge is a layperson and to those of us for whom preclinical genetics are a hazy memory. The lists of references included a wide range of animal studies (mice, cats, rats, hamsters, stallions, male mosquito fish and striped bass). I was concerned as to how much of this could really be evidence of sexual function in the human species.

The book is divided into two halves. The first deals with the effects of drugs on the causation of sexual problems and the second addresses drug treatment for sexual problems. The introduction to the treatment of premature ejaculation says: ‘None of the mentioned agents has been approved by the FDA for the treatment of PE’. It seems unusual to devote a whole chapter on treatment to unlicensed drugs.

Although passing reference is made to ‘psychosocial context’ it would be easy reading this book to feel that the answers to sexual problems lie only in pharmacology. The authors state that: ‘Many men have … unrealistic expectations of their sexual performance’. There was no suggestion that this too needs addressing.

The authors ask even more of us in the consultation. They state: ‘It is critical to obtain a baseline measure of sexual function prior to starting a new pharmacological treatment’. This seems an unachievable goal. We know that doctors are not yet very good at talking with their patients about sex. Furthermore, the time constraints within which we all work mean that this issue will not always have sufficient priority to merit a share of the consultation.

Having felt cause to argue in particular with the way things are said in this book, I do think it has some use in presenting pharmacological information about sexual function. Perhaps that is after all what it intended to do.

Reviewed by Alex Connan, MRCP GP General Practitioner and Family Planning Doctor, Edinburgh, UK

Understanding laboratory tests

The Association of Clinical Biochemists has launched this website to help patients understand about laboratory testing. I suspect (see the review about high vaginal swab testing and reporting) that many doctors might also find it helpful. The home page gives some news items, together with a search box and some drop-down menus. The menus are headed Tests, Conditions and Diseases and Screening, so that information about individual tests or conditions can be located. On the left of the site there is a very useful menu to locate tests in alphabetical order such as how to interpret the terms used in tests (like reference ranges) and tours of what happens to the sample. The contact links are very useful for patients who feel there are omissions on the site. There is a feedback page and the site is peer-reviewed.