LETTERS

resuming pill taking and/or starting the next pack without a break) and to avoid risk of pregnancy (by advising condoms/abstinence for 7 days). EC is not indicated when this advice is followed.

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When is a pill missed?

The latest WHO and CEU guidance for the action to be taken when oral contraceptive pills are missed is2 much more forgiving than the recommendations we have been using to follow in the UK for many years. In particular, the guidance states that women have to miss three or more 30 μg pills before needing to take additional contraceptive precautions. Much depends on how we interpret these words. If a pill is only considered to be ‘missed’ after 24 hours when it is time for the next pill to be taken, then a woman would be following the guidance correctly if she started a new packet of pills after very nearly a 10-day pill-free interval and took no additional precautions at all. Although this may be sufficient for the majority of women, there will undoubtedly be some who ovulate on such a regimen, particularly if they forget more pills later in the packet or during the next month. It seems more sensible to interpret the WHO guidance in the context that if a pill is taken only 1 hour late it has not been missed. At least this is more consistent with what we have told our patients in the past, even if the words are different.

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The new recommendations on missed pills published in April 20053 are based on findings of a WHO Expert Working Group with UK representation.2 These new recommendations are not very different from previous recommendations from the CEU; the FFPRHC2 and the WHO2 (where missed pill rules were applied to a new pill packet two or more days late or if any of two to four pills were missed in Week 1). There was inconsistency, however, in how missed pill recommendations were used in the UK, it is hoped that with the publication of new recommendations and fast information leaflets that guidance and advice given to women will be harmonised throughout the UK.

The CEU does not now use the term ‘late’ pills as it has done in previous guidance. The CEU considers a pill to be ‘missed’ if the male component is completely omitted (more than 48 hours elapsed since taking the last pill). The CEU recommend that action need only be taken when three pills are missed (or two if using a 20 μg pill) in any week of pill taking. Seven pills are omitted every month in the pill-free interval (PFI) without concerns about loss of efficacy. Pills missed in Week 1 may extend the PFI to 10 days. The CEU acknowledge there may be inter-individual variation in risk of ovulation by extending the PFI but available data is reassuring even with a 10-day PFI.

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Editor’s Note

This debate on missed pills has also found its way into The Lancet. Interested readers should refer to: Mansoor D, Fraser IS, Missed contraceptive pills and the critical pill-free interval, Lancet 2005; 365: 1670–1671.

Emergency contraception for women aged over 40 years

The Faculty Guidance document from the CEU on ‘Contraception for women aged over 40 years’1 does provide a wealth of evidence-based practical guidelines on the subject.

I am surprised that in such a voluminous publication, except for a passing comment merely citing two references, no mention is made about emergency contraception (EC), which may provide an additional effective contraceptive option.

The Guidance document spells out that barrier methods are currently used by one-third of the older women using contraception in the UK.2 It would have been appropriate to emphasise that women using barrier methods should be adequately informed and counselled about the methods of EC in case of inability to use or failure during use of barrier contraception.

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References

Reply

Thank you for the opportunity to re-emphasise the safe and effective use of emergency contraception (EC) when contraceptive methods fail or unprotected sex has occurred.

In the CEU Guidance on ‘Contraception for women aged over 40 years’1 our objective was to provide overall guidance on contraceptive choices for women in this age group. We also aimed to highlight and provide information on health concerns specific to this age group of women. Much information was provided on combined hormonal contraception in relation to cardiovascular disease, cancer, bone health and bleeding due to the concerns of women and clinicians on the use of these methods by women over the age of 40 years. Screening was particularly emphasised as this is a commonly used method for women and couples aged over 40 years.

We recognise that in the UK the normally accepted common method of contraception chosen by couples in this age group. However, we perhaps failed to emphasise the importance of informing women about the use of EC should barrier methods fail. The CEU found no evidence to suggest that women aged over 40 years should be prescribed progesterogen-only emergency contraception (POEC) differently from women aged under 40 years. For women of all ages, EC (both POEC and the copper intrauterine device) are effective if started within 72 hours after unprotected intercourse or potential contraceptive failure. The CEU advise that when EC is indicated, women should be counselled and offered both options even if presenting within 72 hours.2

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Chlamydia screening in general practice: a missed opportunity?

The second phase of the National Chlamydia Screening Programme (NCSP) is currently underway in a quarter of primary care trusts in England, covering settings such as family planning, antenatal, colposcopy and termination of pregnancy services as well as general practice.3 There is not much literature that relates to implementing chlamydia screening in general practice, as the RCN and the British Society for Sexual Health Medicine observed there are opportunities to discuss chlamydia screening in general practice.4 The CEU found no evidence to suggest that chlamydia screening would worsen health inequalities by denying screening to those who are least educated and informed to use preventative services and consequently increasing the risk of infection.

We recommend a third concern is the men. The author rightly pointed out that men have responsibility for their sexual health but the only opportunity to screen appeared to be at the time of a clinic check. If men are traditionally perceived to be less users of health services, then every opportunity must be made to offer screening.

In addition, I fail to see why only clinicians should recruit the target groups opportunistically.