When is a pill missed?

The latest WHO and CEU guidance for the action to be taken when oral contraceptive pills are missed is 2 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 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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References

Reply

The new recommendations on missed pills published in April 20051 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.3 The FPCHRHC4 and the WHO5 (where missed pill rules were applied) considered only 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 the WHO FRPRHC5 (which considers 2 missed pills in any week of pill taking) 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: Mansour 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 provides 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 women using EC, which may reflect the different approaches to EC in all countries. The CEU recommend that action need only be taken when three pills are missed (or four 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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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.1 There is not much literature that relates to implementing chlamydia screening in general practice.2–4 The paper by Harris5 in the April 2005 issue of the Journal is very timely. However, I feel he hasn’t considered the full potential of ‘opportunistic’ screening to make the screening more effective.

Harris observed there are opportunities to discuss chlamydia screening in general practice. Chlamydia screening was offered to women aged between 16 and 25 years attending for smear or counselling about contraception, and men aged between 16 and 34 years at a new patient health check appointment. I have several concerns with this approach.

First, the cervical cytology screening schedule in the UK no longer invites women under the age of 25 years. In the paper, three out of the five positive cases were screened during cervical cytology; hence relying on this consultation would potentially miss the group of young women in whom the infection is most prevalent.

Second, although it was good practice to offer chlamydia screening as part of sexual health promotion, offering screening to those who attend only for cytology and contraception 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.

Third, there is a common misconception in the UK that cervical screening is for cervical cancer. It is not a check that can be done at the same time as a cervical cytology check. If men are traditionally perceived to be lower users of health services, then every opportunity must be taken to get them screened.

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

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References

Reply

Thank you for your comments, and 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. Sterilisation is particularly emphasised as this is a commonly used method for women and couples aged over 40 years.

We recognise that in the UK the randomised controlled is a 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 progestogen-only emergency contraception (POEC) differently from younger women aged under 40 years. For women of all ages, EC (both POEC and the copper intrauterine device) are considered safe and well tolerated and offered both options even if presenting within 72 hours.2

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References

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In the pilot screening programmes, reception staff recruited most of the screening subjects in general practice and family planning clinics. Making use of other members of the primary health care team would significantly reduce the burden on clinical staff and therefore the cost of a population-wide screening programme.

Finally, the author attempted to calculate the cost per case detected and treated. A formal economic evaluation which includes administrative and clinical time, would be more helpful, but is beyond the scope of his paper. Some of these issues are already addressed in the economic evaluation arm of Chlamydia Screening Studies (CLASS).

Our practice started testing for chlamydia and other sexually transmitted infections (STIs) in the risk groups since June 2004 as part of National Enhanced Service (NES) for More Specialised Sexual Health Services. We put up posters and information in the waiting room to encourage testing; this enabled patients to feel empowered to request screening. Clinicians also felt less embarrassed about bringing up the subject of screening, since it was routine. We have identified and treated STIs in the waiting room to encourage that screening was restricted in the practice and these can be taken to reception staff directly in the offer of screening.

With regard to the economic evaluation, as I clearly stated in my article this did not include administrative or clinical time, which I agree would have been more helpful; however, this was beyond the scope of the article.

Like Dr Ma we have empowered our patients to make decisions about their screening needs. I wish Dr Ma every success with the article he has submitted to the Journal on chlamydia screening in general practice.

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Cerazette for premenstrual tension

It was interesting to read Mr Ali Kubba’s letter published in the October 2004 issue of your Journal on the above subject.1

I have prescribed Cerazette® for a small cohort of patients (eighty patients) in my PM’S/Menopause Clinic, who presented with both psychological and physical symptoms within the last year. In 68% patients there was a marked improvement in the psychological symptoms and moderate improvement was seen in physical symptoms within 3 months of starting the treatment.

One patient did not show any improvement in her psychological or physical symptoms and since went on fluoxetine with marked improvement of her symptoms, and one patient’s psychological symptoms got worse to the extent of personality changes and suicidal tendencies and these symptoms completely disappeared on stopping Cerazette.

All these patients were sexually active young women with an age range of 25-45 years. Of the six women who showed an improvement in their symptoms, only three women became amenorrheic with this treatment; the other patients, despite an improvement in their symptoms, had irregular cycles.

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Spinal fracture in a young Depo-Provera user

Following the latest alarm1 on the risks of osteoporosis in Depo-Provera® users, a 22-year-old patient of ours was admitted in January 2005 with a fractured vertebra following low-impact trauma. She had been on Depo-Provera for almost 3 years. She had had irregular menstrual spotting until now with only a slight bleeding as is common with long-term injectables.

She first attended our clinics at age 15 years with heavy regular cycles, weighing 8 stone and smoking 10 cigarettes per day. The only other possibly relevant point in her medical history was her mother’s muscle wasting disease on the left side of her back. She had been a combined pill user changing to Depo-Provera at age 19 years. She now weighs 10 stone 13 pounds, her height is 5’1” and she has a body mass index of 29. She stopped smoking 2 months ago.

The vertebral fracture occurred at home when she was putting on her shoes, lost her balance and fell backwards onto the floor. She is on no medication, has never taken corticosteroids, has had no symptoms of oestrogen lack, and goes to sleep on her back. She is now on bone density testing and had a normal result.

The hospital immediately took her off Depo-Provera and the fracture occurred. Does this case illustrate that an association does not equate with causation, at least for this individual?

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Stop ‘QOfing’ and moaning: start lobbying!

Following on from my last rant,2 I feel compelled to write again to represent another view from primary care. Dr Bugerum’s dismisses the incentive scheme operating in general practice under the new contract that is the Quality and Outcomes Framework (QOF), and notes many of these incentives relate to chronic disease management but do not relate to sexual health.3

The strength of the QOF is it rewards practices for achieving prescribed outcomes such as target blood pressures and cholesterol levels, not merely the process of intervention such as measuring blood pressure and cholesterol. The fact that many GPs are exceeding their aspirations on QOF targets is a victory for public health and chronic disease management.

One thing I do agree with Dr Bugerum is the lack of incentives for provision of sexual health care; this is an issue that the Royal College of General Practitioner’s Sex, Drugs and HIV Task Group have been working hard to raise with the GP contract negotiators. Separating sexual health from the core contract to an enhanced service only discourages GPs to offer even the most basic of sexual health care and promotion such as contraception. Merely having policies on preconception advice and emergency contraception is not adequate to achieve sexual health outcomes aspired to in the National Strategy for Sexual Health and HIV.2 Under the old contract, any contraception activity enabled us to claim the contraception fee, which was worth about £17 per patient per year; QOF points relating to contraception are only worth £240 for an average practice of 5000 patients in the 2005/2006 financial year. Sexual health promotion such as contraception advice, screening for sexually transmitted infections and use of long-acting reversible contraceptives are effective in reducing sexual all health and unwanted pregnancies. GPs with an interest in sexual health should be joining forces to lobby the GP contract negotiators; sexual health work should be recognised in the core contract and QOF.

We should all stop moaning and start lobbying!

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