LETTERS

Letters to the Editor

Practice-based commissioning

Richard Ma raises some very interesting points in his commentary about practice-based commissioning (PBC) and its impact on sexual health services in this issue of the Journal. In my view, he is right to encourage sexual health providers to start thinking now about the opportunities that the new arrangements may provide for developing a more integrated service that encompasses contraception, abortion and STI provision in a community setting. A major barrier to doing so is the 1967 Abortion Act, which states that abortions can only take place in NHS hospitals and clinics. It is widely held that a creative collaboration with a local acute trust may overcome this difficulty, as is already the case in some areas.

While PBC does present opportunities for new partnerships and improved patient pathways, there are also risks associated with it. For example, current PBC models do not practice the need for dedicated contraceptive services, and with the increased influence that general practice will have over the type of services that may mean that community contraceptive clinics are no longer commissioned to provide services.

Where this happens, as is highly likely in some parts of the country, we fear that the lack of specialist knowledge, which will have far reaching consequences for contraceptive services not only now but in the future, may undermine the three-level model for sexual health services that is the basis of the National Strategy for Sexual Health and HIV. The already greatly stretched training capacity, which is unable to meet current needs, will be further reduced. And professionals providing Level 1 and 2 services will no longer have the support they need from family planning consultants and specialist family planning nurses. Above all, many women will no longer have access to a full range of contraceptive methods because their general practice does not provide them.

When the Government’s proposals for changing the emphasis of primary care trusts (PCTs) away from providing services to commissioning were first announced, the indication was that PCTs would no longer provide services at all. This created major concerns for sexual health services because of the lack of alternative providers (other than for some specific services). At the same time, there are concerns that the new arrangements may mean that community contraceptive clinics are no longer commissioned to provide services.

NICE Guidance on LARC

I welcome the useful advice in the National Institute for Health and Clinical Excellence (NICE) long-acting reversible contraception (LARC) Guidance (1) that progestogen-only methods may be used by women who have migraine with or without aura.1 However, although the subsequent recommendation by NICE is that “progestogen-only methods, including the IUS, may be used by women who have migraine with or without aura”, it is unclear to me if NICE is suggesting that the WHO-MEC guidance does or does not apply.

I understand the concern of increased headache reported in LNG-IUS users. However, there are no data to support that its use is associated with headache. Although it is recognised that women who have migraine, particularly with aura, and take combined oral contraceptive pills are at increased risk of ischaemic stroke, there is no evidence that this is the case for progestogen-only contraception.3-5 Hence, progestogen-only contraception can be used by women with any type of migraine, irrespective of whether aura is present before, or develops after, commencing the method.6 Clearly, it may be worth considering stopping the method to assess whether or not symptoms improve, but this should be on clinical grounds, not on safety. Hence I recommend that both NICE and WHO should consider amendments to WHO MEC category 2 for initiation and continuation of all progestogen-only methods.

E A MacGregor

Director of Clinical Research, The City of London Midwives’ Training Centre, 2 Charterhouse Square, London EC1J 6DX, UK. E-mail: ann.macgregor@sitorangoram.co.uk

Reference


Emergency contraception and liver enzyme-inducing drugs

The CEU Guidance on drug interactions with hormonal contraception1 includes discussion on progestogen-only methods and combined injectable contraceptives. Results of an international, multicenter, case-control study. World Health Organization Collaborative Study of Cardiovascular Disease and Steroid Contraceptives. Contraception 1998; 57: 315-324.


References

1 Faculty of Family Planning and Reproductive Health Care, British Medical Association and Royal Pharmaceutical Association of Great Britain, Clinical Effectiveness Unit, University of Aberdeen; 2005. 10.1783/147118906775275280

2 British National Formulary (BNF), Volumes 49 and 50. 2005. BNF states in the preface on page iii that the current edition must always be used when making clinical decisions.1

Please clarify this discrepancy.

Nader Al-Hassan

MBCh, DFFP

General Practitioner, Hardwicke House Surgery, Stuart Street, Sudbury, Suffolk CO10 2AY, UK. E-mail: naderalhassan@hotmail.com

Reply

Thank you for the opportunity to respond to the letter from Dr Nader Al-Hassan outlining apparent inconsistencies within our CEU Guidance on drug interactions with hormonal contraception.1 I share Dr Al-Hassan's frustrations about conflicting guidance from different sources. As Dr Al-Hassan says, in our 2003 CEU Guidance on emergency contraception2 we recommended a regimen of levonorgestrel 2.25 mg as a divided dose for women taking concurrent enzyme-inducing drugs; in our 2005 Guidance on drug interactions with hormonal contraception we recommend 2.25 mg as a single dose. There is no research evidence about the most appropriate emergency contraception regimen for women taking concurrent enzyme-inducers and our recommendation is that the WHO-MEC guidance on drug interactions Guidance was, in fact, based on the advice in the volume of the BNF that was current at the time of writing. In our Guidance we refer to Volume 88 of the BNF (September 2003). Paragraph 4.04 of that volume contains the advice on interactions with hormonal emergency contraception: “the dose of levonorgestrel should be increased to 2.25 mg taken as a single dose”. We note that in an earlier volume (Volume 43) and in a later volume (Volume 49) the BNF does recommend a divided dose in this circumstance. We do not know the reason why the BNF has altered its advice from a divided dose to a single dose, and back again, in successive volumes. However, on the basis of available data, we doubt that the difference in regimen makes any difference to efficacy. The CEU is currently updating our Guidance on emergency contraception for publication in the April 2006 issue of this Journal. We will again be reviewing available evidence in developing an updated recommendation on concurrent emergency contraception and enzyme-inducers.

Gillian Penney

FRCOG, MFFP

Honorary Director, PPBRC Clinical Effectiveness Unit, University of Aberdeen, Aberdeen, UK. E-mail: g.c.penney@abdn.ac.uk

NICE Guidance on LARC

I welcome the useful advice in the National Institute for Health and Clinical Excellence (NICE) long-acting reversible contraception (LARC) Guidance (1) that progestogen-only methods may be used by women who have migraine with or without aura.1 However, although the subsequent recommendation by NICE is that “progestogen-only methods, including the IUS, may be used by women who have migraine with or without aura”, it is unclear to me if NICE is suggesting that the WHO-MEC guidance does or does not apply.

I understand the concern of increased headache reported in LNG-IUS users. However, there are no data to support that its use is associated with headache. Although it is recognised that women who have migraine, particularly with aura, and take combined oral contraceptive pills are at increased risk of ischaemic stroke, there is no evidence that this is the case for progestogen-only contraception.3-5 Hence, progestogen-only contraception can be used by women with any type of migraine, irrespective of whether aura is present before, or develops after, commencing the method.6 Clearly, it may be worth considering stopping the method to assess whether or not symptoms improve, but this should be on clinical grounds, not on safety. Hence I recommend that both NICE and WHO should consider amendments to WHO MEC category 2 for initiation and continuation of all progestogen-only methods.

E A MacGregor

Director of Clinical Research, The City of London Midwives’ Training Centre, 2 Charterhouse Square, London EC1J 6DX, UK. E-mail: ann.macgregor@sitorangoram.co.uk

References


Emergency contraception and liver enzyme-inducing drugs

The CEU Guidance on drug interactions with hormonal contraception1 includes discussion on progestogen-only methods and combined injectable contraceptives. Results of an international, multicenter, case-control study. World Health Organization Collaborative Study of Cardiovascular Disease and Steroid Contraceptives. Contraception 1998; 57: 315-324.
