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Journal Review

Factors predisposing women to chronic pelvic pain: systematic review. Latthe P, Mignini L, Gray R, Hills R, Khan K. *BMJ* 2006; **332**: 749–755

This systematic review identified over 5500 citations and selected 122 studies to review, incorporating a cohort of almost 95 000 women. Studies were grouped according to whether the study population's main complaint was dysmenorrhoea, dyspareunia, or non-cyclical pelvic pain. The authors evaluated more than 60 risk factors for chronic pain and identified a consistently complex multifactorial aetiology for each of these groups (prominent risk factors included the presence of pelvic pathology, history of abuse, and coexistent psychological morbidity).

The multifactorial aetiology confirms the benefit of a multidisciplinary approach to chronic pelvic pain with input from a gynaecologist with special interest and psychologists. However, it is important to note that studies investigating patients with irritable bowel syndrome as a co-morbid condition were not included in the review. This is a group of patients who may present with chronic pelvic pain, and therefore a pelvic pain service should probably also involve a gastroenterologist.

Having identified the main aetiologies of chronic pelvic pain, the authors concluded that further research (in the form of randomised controlled trials) is required to evaluate the benefit of targeted management to potentially modifiable factors.

Reviewed by **Philip Dutton**, MB ChB
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Incidence of severe reproductive tract complications associated with diagnosed genital chlamydial infection: the Uppsala Women's Cohort Study. Low N, Egger M, Sterne JAC, Harbard RM, Ibrahim F, Lindblom B, *et al*. *Sex Transm Infect* 2006; **82**: 212–218

This large, retrospective, population-based cohort study provides convincing evidence that the incidence of severe complications associated with chlamydia infection is not as high as previously reported.

The study was set in Sweden, the first country to introduce a nationwide programme of opportunistic chlamydia screening. Over 43 000 women aged between 15 and 24 years in one county were followed from 1985 to 1999. During the 14-year study period, 71% of women were screened for chlamydia and 13% had at least one episode of chlamydial infection. Using laboratory and hospital record linkage, the incidence of hospital-diagnosed pelvic inflammatory disease (PID), ectopic pregnancy and infertility was compared between woman who tested positive for chlamydia, tested negative and were never tested. Although a positive chlamydia result was consistently associated with increased complications, the difference was not as large as suggested by clinical studies. For example, the cumulative incidence for PID rose from 4.0% in those with a negative screen to only 5.6% in those who had a positive chlamydia result, and was 2.9% in those who were never screened. Low socioeconomic status was also shown to be associated with a marked increase in all complications.

While these results are reassuring for women, the authors claim that the cost-effectiveness of chlamydia screening programmes may have been overestimated. To establish the true risks of chlamydial infection, future studies need to include PID diagnosed in primary care and to examine the implications of repeated episodes of infection.

Reviewed by **Kate McNab**, MB ChB
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One-stop shop versus collaborative integration: what is the best way of delivering sexual health services? French RS, Coope CM, Graham A, Gerressu M, Salisbury C, Stephenson JM, *et al*. *Sex Transm Infect* 2006; **82**: 202–206

The National Strategy for Sexual Health and HIV recommends integration of sexual health services, but what does integration actually mean and on what evidence is this recommendation based? French and colleagues reviewed the evidence that is currently available from experiences of integration in the UK and they interviewed key informants involved in developing the strategy document.

According to the paper, the theoretical benefits of a one-stop shop approach include convenience, better continuity of care, fewer provider contacts, less need for interagency referral and the potential for staff to extend roles. A combined service may be more holistic and better able to target those individuals who are not aware that they need the alternative service. In financial terms, savings may be made from cost sharing and avoidance of duplication but this remains to be proven.

Despite evidence that working within an integrated service improves staff motivation, concerns have been voiced about loss of specialist skills and clashes between contradictory service cultures. Other potential weaknesses include reduced funding for satellite services and increased appointment times.

The authors conclude that there is currently insufficient evidence to suggest that one-stop shops are any more or less effective than separate services that work collaboratively. Although the paper leaves important questions unanswered, it does provide a useful review of the different levels of integration, the various models of service structure, and the potential pitfalls and barriers to integration of sexual health services.

Reviewed by **Louise Melvin,** MRCOG, MFFP
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Risk of nonfatal venous thromboembolism with oral contraceptives containing norgestimate or desogestrel compared with oral contraceptives containing levonorgestrel. Jick SS, Kaye JA, Russmann S, Jick H. *Contraception* 2006; **73**: 566–570

This is a nested case control study, based on information from PharMetrics, a USA-based company that records information on claims paid by managed care plans. The authors calculated relative risks of non-fatal venous thromboembolism (VTE) among 15–39-year-old current users of oral contraceptives (OCs) containing norgestimate with 35 μg ethinylestradiol (EE), desogestrel with 30 μg EE or levonorgestrel with 30 μg EE, both monophasic and triphasic preparations, during the period January 2000 to March 2005.

Based on 281 newly diagnosed idiopathic cases of VTE and 1055 controls, they found that the adjusted odds ratios for non-fatal VTE comparing norgestimate- or desogestrel-containing OC users to users of levonorgestrel-containing OCs were 1.1 [95% confidence interval (CI) 0.8–1.6] and 1.7 (95% CI 1.1–2.4), respectively. The incidence rates of VTE were 30.6 (95% CI 25.5–36.5), 53.5 (95% CI 42.9–66.0) and 27.1 (95% CI 21.1–34.3) per 100 000 woman-years for users of norgestimate-, desogestrel- and levonorgestrel-containing OCs, respectively.

The database does not give information on height, weight, family history or smoking status, all of which have been shown to be highly relevant in such analyses. Thus, as in previous studies by this group, and others not able to control for these variables, the authors conclude there are differences in VTE incidences between the preparations, but cannot exclude confounding and bias by potential differences in these important parameters. Incidentally, this would not be apparent from the abstract, highlighting the danger of relying on information from abstracts, without reading the full paper.

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