


Journal Review


This systematic review identified over 5500 citations from which 122 studies were selected to be reviewed, 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-cyclic 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 comorbid 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 be available on newly diagnosed cases.

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
SHO3 in Obstetrics and Gynaecology, St John’s Hospital, Scotland, UK


This large, retrospective, population-based cohort study provides convincing evidence that the incidence of severe complications associated with chlamydial 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 women 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
SHO3 in Obstetrics and Gynaecology, Royal Infirmary of Edinburgh, Edinburgh, UK


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 abstracts, without reading the full paper.

They find that although more than 30 abstracts were included in the review, there was a lack of relevant evidence. Of the 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 levaogestrel or desogestrel with 30 µg EE, 30 µg EE, both monosopnic 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 levagestrel-or desogestrel-containing OCs were 1.1 [95% confidence interval (CI) 0.9–1.2] 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 48.2–60.0) and 27.1 (95% CI 21.1–34.3) per 100 000 woman-years for users of norgestimate- or desogestrel- and levagestrel-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 database, highlighting the danger of relying on information from abstracts, without reading the full paper.

Reviewed by Anne Szarewski, PhD, FFFP
Clinical Consultant and Honorary Senior Lecturer, Cancer Research UK Centre for Epidemiology, Mathematics and Statistics, Wolfson Institute of Preventive Medicine, London, UK