
Objectives and methodology: The purpose of this study was to assess the incidence and severity of premenstrual syndrome (PMS)-type symptoms in patients converted from a 21/7 combined oral contraceptive (COC) regimen to an extended regimen (24 weeks). This was a single-centre prospective observational study in 114 women using a locally devised single-item premenstrual symptom questionnaire, the Scott and White (S&W) Mood Scale, and the more generally accepted and validated Penn State Daily Symptom Report (DSR 17). Subjects were followed during a two-cycle 21/7-day COC regimen and then were switched to a 168-day extended regimen of a COC containing 3 mg drospirenone and 30 mg ethinylestradiol (DREP/EI) (Yasmin®). A total of 111 subjects completed the 21/7 regimen and 102 (92%) the extended regimen.

Results: The study confirmed the presence of PMS symptoms in women using standard 21/7 COCs and that these symptoms reached peak intensity during the pill-free interval. A statistically significant decrease in DSR 17 scores was noted when switching from a 19-nortestosterone progestogen containing COC to the drospirenone COC. This may be a reflection of the anti-mineralocorticoid and anti-androgenic effects of this progestogen but as this was not a randomised trial head-to-head comparison trial caution should be exercised in making this conclusion.

Discussion: Elimination of the 7-day pill-free interval with the 168-day extended regimen resulted in a statistically significant reduction in premenstrual symptoms that was more pronounced in the last two 28-day intervals of the regimen. Subjects were classified as exhibiting low or high cycler variability from the 21/7 regimen. Not surprisingly, those with low variability (less PMS) showed less improvement during the extended regimen. The limitations of the study were that it lacked a placebo arm; subjects acted as their own ‘controls.’ Also, the subjects were heterogeneous in that:

1. 60% of those on the 21/7 regimen had PMS symptoms.
2. They were on a variety of COCs to begin with.
3. They may or may not have had endogenous PMS before starting the COC.

Take home messages: The most valuable information provided by this study for the clinician is that:

1. COCs may induce PMS symptoms, especially when used in a 21/7 regimen.
2. There may be advantages to prescribing COCs containing anti-mineralocorticoid and/or anti-androgenic progestogens to reduce PMS symptoms.
3. There are significant benefits in using extended regimen preparations rather than 21/7 preparations in controlling/reducing PMS symptoms.
4. Extended cycle regimens used for PMS may take a few months to become fully effective.

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How to improve the poor sexual health outcomes of young people in the UK has been the focus of a lot of research, and the topic of sex education in schools arouses at least as much impassioned emotional debate as scientific rigour (see rapid responses to the BMJ editorial accompanying this article). The SHARE programme was developed in the early 1990s to be delivered by teachers in secondary schools to pupils aged 15–15 years, with the primary aim of reducing unwanted pregnancies. It was compared, in a cluster randomised trial, with existing sex education programmes in schools. Interim evaluations were encouraging, with teachers and pupils evaluating the SHARE programme more positively than the control programmes, and some improvement in knowledge and reduction in sexual activity in girls, although not in boys. This study now compares the SHARE and control programmes in schools with no sex education, and in schools receiving SHARE. It confirms the presence of highly statistically significant decrease in DSR 17 scores (reduced premenstrual syndrome) associated with the SHARE programme. Uptake was between 55% in the control group and 75% in the SHARE group. This study was pre-planned and its results should therefore be viewed as highly statistically significant.

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Unintended pregnancy and use of emergency contraception among a large cohort of women attending for antenatal care or abortion in Scotland. Lahk F, Glaisier A. Lancet 2006; 368: 1782–1787

Unintended pregnancy is common and can significantly affect the life of the women concerned regardless of the outcome of the pregnancy.

During the 8-month study period, 3815/5630 (68%) eligible women attending abortion services (n = 907), miscarriage clinic (n = 615) or antenatal clinic (n = 2293) in a large hospital in Scotland completed a self-administered questionnaire. Uptake was between 55% in the abortion clinic and 75% in the antenatal clinic. Patients were asked about their pregnancy intention using a validated intendedness instrument and about use of emergency contraception during the conception cycle. Unsurprisingly, 65.7% of women in the antenatal clinic had a high intendedness score whereas 89.7% of those attending the abortion clinic had a high unintendedness score. Interestingly, 26.6% of women attending antenatal, 22.8% of women attending miscarriage and 10.0% of women attending abortion clinic were ambivalent about their pregnancy intention. Moreover, 7.7% of women in the antenatal clinic and 11.9% in the miscarriage clinic had a high unintendedness score. Younger age was associated with unintended pregnancy in the antenatal and miscarriage clinic but not in the abortion clinic.

Emergency contraception (EC) was used by 11.8% of women seeking abortion and 1.0% attending antenatal care and correlated strongly with intendedness score. Again, young age was associated with unintended pregnancy in the antenatal and miscarriage clinic but not in the abortion clinic.

With high levels of unintended and ambivalent conceptions and low uptake of EC there is clearly an urgent need to better understand the risk (of pregnancy) perception and patterns of contraceptive behaviour of women in the UK.

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LETTERS TO THE EDITOR

Letters to the Editor are welcome and generally should not exceed 600 words or cite more than five references. For comments on material published in the most recent issue of the Journal, correspondence should be received within 4 weeks of dispatch of that Journal to be in time for inclusion in the next issue. When submitting letters correspondents should include their job title, a maximum of two qualifications and their address(es). A statement on competing interests should also be submitted for all letters. Letters may be submitted to the Editor or the Journal Editorial Office (details on page 73).