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JOURNAL REVIEW

Contraception for the older woman: an update. Bhatena RK, Guillebaud J. *Climacteric* 2006; **9**: 264–276

So much has been written about contraception for the young adolescent that the implications of an unplanned pregnancy for the older woman can easily be overlooked.

This comprehensive update pulls together peer-reviewed, randomised, controlled trials and observational studies from the last 6 years. It also refers to guidelines from the Royal College of Obstetricians and Gynaecologists, the Clinical Effectiveness Unit of the Faculty of Family Planning and Reproductive Health Care, the Committee on Safety of Medicines, the World Health Organization and the International Planned Parenthood Federation.

It gives evidence-based advice on all methods of contraception (including emergency contraception) and looks at their suitability for this age group, stressing the non-contraceptive benefits that such methods may possess – including reduction of menorrhagia with the intrauterine system, and reduction in vasomotor symptoms and increase in bone mineral density with the combined oral contraceptive – all useful advantages for the older woman.

Although in the UK female sterilisation is the most commonly used method of contraception in women aged over 40 years, this paper suggests that the need for this procedure should be reviewed. Long-acting reversible methods are equally effective and offer additional benefits, particularly in view of the increasing number of failed relationships and subsequent requests for reversal of sterilisation.

The paper also considers the questions of when contraception can be discontinued and the value of testing follicle stimulating hormone levels when using different forms of hormonal contraception.

This well-referenced update provides clinicians with a relevant source of the latest information on this topic.

Reviewed by **Gilly Andrews**, RGN
Clinical Nurse Specialist in Reproductive and Sexual Health, King's College Hospital, London and Menopause Nurse Specialist, The Lister Hospital, London, UK

Association of estrogen and progestin potency of oral contraceptives with ovarian carcinoma risk. Luie G, Thompson P, McDuffie KE, Carney ME, Terada KY, Goodman MT. *Obstet Gynecol* 2007; **109**: 597–607

It is widely accepted that use of the combined oral contraceptive pill (COCP) reduces the risk of epithelial ovarian carcinoma. However, during the last 30 years there have been significant changes in the oestrogen and progestogen content of the COCP, with the aim of decreasing adverse effects. This population-based case-control study examined the effect of varying oestrogen and progestogen potencies on ovarian carcinoma risk.

The study identified 745 women who had a histological diagnosis of primary epithelial ovarian carcinoma. A total of 943 controls were randomly selected from annual household survey data and a frequency-matching approach used to ensure comparability to cases. Each participant was interviewed to record sociodemographic information, menstrual, reproductive and gynaecological histories, and exogenous hormone use. Photograph albums were used to aid identification of COCP preparations. Women identified as having exclusively used the COCP were divided into six categories: (i) unknown preparation, (ii) high oestrogen and high progestogen, (iii) high oestrogen and low progestogen, (iv) low oestrogen and high progestogen, (v) low oestrogen and low progestogen and (vi) various potency OCP users. Oestrogen levels greater than 0.035 mg ethinylestradiol were defined as high oestrogen and less than 0.035 mg as low oestrogen potency. Progestogens were expressed in milligrams of norgestrel equivalent. Those less than 0.3 mg norgestrel were classified as low potency. Participants using parenteral, sequential or progestogen-only contraceptives were excluded. Odds ratios (ORs) were calculated for the association of these OCP categories with ovarian carcinoma risk. Adjustments were made for an extensive list of variables including age, ethnicity, family history of ovarian cancer, gravidity, age at menopause and duration of COCP use.

Use of any COCP was associated with a

50% reduction in epithelial ovarian carcinoma risk. Reduced risk was observed in all categories of COCP by potency when compared with participants who never used hormonal contraception, with ORs of 0.62, 0.55, 0.45, 0.19 and 0.26 for categories (ii) to (vi), respectively. Although the odds of ovarian cancer were lower in users of low potency COCPs than in users of high potency COCPs, this difference was not statistically significant. The study then went on to analyse women exclusively using COCPs containing a single progestogen, norethindrone, with no inter-individual variation in dose. They found a significant decreased risk of developing ovarian carcinoma in users of low dose (0.5 mg or lower) norethindrone compared to women taking high-dose preparations.

The authors concluded that COCPs with low oestrogen and progestogen potency provided significant reduction in epithelial ovarian carcinoma risk. However, actual numbers of participants using low-dose preparations were small (3 cases and 12 controls). The authors suggest that the protective effect may be due to ovarian suppression, which occurs regardless of the potency of the COCP. They suggest the improved protection with low potency preparations may be due to increased compliance. Limitations of the study include reliance of patient recall for preparations of COCP. This resulted in 347 women being classed as 'unknown OCP' users, casting doubt on the reliability of recall in the other groups. In addition, oestrogenic and progestogenic components of the COCP have unique pharmacological features and are not completely comparable. Nonetheless, this study does suggest that low potency COCPs are of equal efficacy as high potency preparations at reducing epithelial ovarian carcinoma. Future studies with larger sample groups are needed to confirm the association and aid risk-benefit analysis for individual women.

Reviewed by **Jackie Maybin**, BSc, MBChB
ST3 in Obstetrics and Gynaecology, Simpson Centre for Reproductive Health, Royal Infirmary of Edinburgh, Edinburgh, UK

READERS' CONTRIBUTIONS INVITED ON 'A BETTER WAY OF WORKING'

Continuing in this issue (see article on page 193) is the feature entitled 'A Better Way of Working', the purpose of which is to disseminate service delivery suggestions likely to be of interest and relevance to the Journal's readership.

Readers are invited to submit suggestions based on their own personal experience for consideration by the Journal Editor. Contributions should not exceed 250–500 words and should be written in a standardised format responding to the following four questions (or similar): Why was change needed? How did you go about implementing change? What advice would you give to others who might be considering a similar course of action? How did you show that the change had occurred?

All contributions should be submitted via the Journal's online submission system at <http://jfprhc.allentrack.net>.