Sisters doing it for themselves
I was interested to read the commentary by Anne Szarewski describing how to... as EC and it is not licensed for such use.

LETTERS TO THE EDITOR

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Reference

Reply

I agree entirely with Dr Robinson1 that long-term health effects of longer-cycle combined oral contraceptive (COC) use have not been formally studied for more than a few years and we should ensure that monitoring continues. However, we should not find it surprising that women bleeding in fact not the norm for healthy, reproductive age women. As Thomas et al. have pointed out: “in-hunter-gatherer times, women had infrequent menstruations because they had closely spaced pregnancies, they breastfed their infants for long intervals (which suppresses ovulation and menstruation), and they died before reaching menopause. Prehistoric women had as few as 50 menstrual cycles per lifetime, whereas the modern woman has approximately 450 bleeding episodes”2. In addition, the bleeding that occurs during the pill-free interval is simply due to hormone withdrawal, not to any physiological need. The studies of longer cycle/continuous pill-taking regimes have so far not given any indication that the adverse event or metabolic profile of extended-regimen oral contraceptives differs in any clinically significant manner from traditional 28-day regimens, while having many health benefits3. Indeed, even a Cochrane Collaboration review in 2005 concluded that “continuous dosing of COCs is a reasonable approach for women without contraindications to COCs”4.

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References

Genuine Depo-Provera® failure

After reading the case report of Lucinda Farmer and Elizabeth Patel entitled ‘Contraceptive failure of Depo-Provera®: long-acting reversible contraceptive (LARC) methods do fail too’ in the January 2009 issue of this Journal1 we would like to report a case of genuine Depo-Provera® failure. Recently, a 23-year-old girl came to our family planning clinic with abdominal pain, breast tenderness, nausea, vomiting and tiredness off and on for 1 week. The patient was fit and healthy, with a body mass index (BMI) of 19, was a light smoker and normotensive. The patient had used Injection Depo-Provera® from age 15 to 21 years and had been happy with the method. She started Depo-Provera on 19 November 2008 on the second day of her cycle at her general practitioner’s surgery and received the injection in her buttock. She had another injection at her surgery 12 weeks later on 11 February 2009. She had one episode of bleeding for 3 days, which began on 18 January 2009. On history and examination she demonstrated symptoms of pregnancy, and bimanual examination showed an anteverted 8-week-sized uterus with no cervical excitation or tenderness. On ultrasound scan, a pregnancy test was positive and she opted for termination of pregnancy. Her gestation was 9 weeks 4 days by ultrasound scan.

We would like to highlight that failures can still occur with perfect use of Depo-Provera. Although current FSRH Guidance on Sexual and Reproductive Healthcare (FSRH) and National Institute for Health and Clinical Excellence (NICE) guidance mention a low failure rate (i.e. 4 in 100) over 2 years, patients may on occasion inject given in accordance with the licensed use of every 12 weeks plus 5 days, higher failure rates with typical use up to 7% were found in the study of Kost et al.2.

Pregnancy should be always considered in women presenting with appropriate symptoms, even when Depo-Provera has been given regularly within the licensed period.

We agree with the suggestion of Drs Farmer and Patel that delayed diagnosis of an unplanned pregnancy could result in delay in seeking either abortion care or antenatal care.

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References

IUD as emergency contraception

I read with interest the article by Moss et al.1 in the April 2009 issue of the journal about the understanding of intrauterine contraception by obstetric and gynaecology trainees. I would question some of the article’s conclusions. Without publishing the list of ‘correct answers’ it is not possible to know how I would have been rated on some of the questions.

In particular ‘An IUS is effective as emergency contraception’ I would certainly have answered in the affirmative.

We all know that the intrauterine system (IUS) is not licensed as emergency contraception (EC) and never will be because of its cost, but if it were being planned as the ongoing method of contraception, it would certainly be effective as EC. Postcoital intrauterine device (IUD) is not relying on its copper content for its efficacy. The copper inhibits sperm mobility and the ability to fertilise the ovum. When it is fitted after sex, it is reliably effective to prevent implantation. Therefore any IUD would be effective, including the IUS. It therefore follows that it would be safe to fit the IUS on any day up to the estimated time of possible implantation – Day 19 in a 28-day cycle. It would not of course be the ideal time in the cycle, but might well prevent an unplanned pregnancy in a patient where you are not certain that she will return at a more ideal time.

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Reference

Reply

The Clinical Effectiveness Unit (CEU) would like to refute the suggestion in Dr Devonald’s letter1 that IUS should not be considered for use for postcoital emergency contraception (EC). There is no evidence that the LNG-IUS is effective as EC and it is not licensed for such use.