Sisters doing it for themselves

I was interested to read the commentary by Anne Szarewski describing how to individually tailor a woman’s combined oral contraceptive (COC) regimen to minimise the amount of breakthrough bleeding she has to experience each year.1 However, in view of the article on repeat abortion (Das et al.) in the same issue of the journal, we should not be more concerned in preventing pregnancy in COC users?2 Das et al. state that 35% of first attenders were using COC and 55% at repeat abortion.

It is not uncommon to see patients who have become pregnant on the COC pill despite taking it perfectly. In my experience, some patients unfortunately only become pregnant on the COC pill despite taking it without fault, some patients unfortunately on more than one occasion, having been restarted on their original COC following the end of their pregnancy. These failures of the method could be attributed to the individual woman ovulating as a 7-day pill-free interval is too long for her ovaries to remain quiescent. In view of this, a 24/4 regimen should be the norm but the drug companies seem slow to change their products.

Several alternative formulations such as 24/4 or continuous-use pill regimens are available in other countries including the USA and Australia, both of which are currently available in the UK, although one has been granted a licence here with a launch date awaited.3 This will no doubt come at a price. Surely all the COC manufacturers should provide a product that is more effective? However, I am sure that there is still a need for a further licence to enable a change to a 24/4 formulation for the cheaper generic COCs would make drug companies reluctant. We can never be certain which patient will fall pregnant despite full compliance with the COC taking ‘rules’ – what is certain is that there will be some women who this affects each year, and they are likely to be your patients who are relying solely on contraception, and may be more than those on whom in this day and age we have the knowledge to prevent these unwanted pregnancies.

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References

Reply

I agree entirely with Dr Robinson1 that 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 overlook the fact that monthly bleeding is 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 menstruations 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 any physiological event. The studies of longer cycle/continuous pill-taking regimens 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 benefits.3 Indeed, even a Cochrane Collaboration review in 2005 concluded that “continuous dosing of COCs is a reasonable approach for women with contraindications to COCs”.4

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Genuine Depo-Provera® failure


I would like to refute the suggestion in Dr Devonald’s letter1 that the levonorgestrel-releasing intrauterine device (LNG-IUS, Mirena®) can still occur with perfect use of Depo-Provera. Although current Family Planning and Reproductive Healthcare (FSRH) and National Institute for Health and Clinical Excellence (NICE) guidance mention a low failure rate (i.e. 4 in 1000) over 2 years1, there is no proof that the progestogen-only injectable 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 use 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

Use 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.2

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 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. IUS is less effective than 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 relying on the barrier effectiveness 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 letter that the IUS is not licensed as emergency contraception (EC). There is no evidence that the LNG-IUS is effective as EC and it is not licensed for such use.