OCs and VTE: a practical answer to an old question

In a recent commentary in this journal, Jürgen Dinger1 argued that “the risk of VTE [venous thromboembolism] attributable to COCs [combined oral contraceptives] is a class effect, primarily dependent on the dose of estrogen” and that the type of progestogen used in the COC probably does not influence this risk. In an editorial in the British Medical Journal that accompanied the publication of the two largest studies to date on this topic, Nick Dunn2 concluded: “All of the more recent progestogens, possibly except norgestimate, may seem to be at a disadvantage with regard to VTE”.

As VTE is a very rare event, it is unreasonable to expect the answer to the progestogens and VTE question from a randomised controlled trial. We may thus never be able to exclude residual confounding as a possible explanation for the higher VTE rates found with newer progestogens. Luckily in clinical practice this does not matter much. For COCs, as for any treatment, health professionals should first recommend the safest and most effective treatment, and in the absence of knowledge differences between treatments we should then consider costs.

Most patients requesting a COC request it solely for contraception. Most of these patients will be prescribed a COC containing a second-generation progestogen, usually levonorgestrel (LNG). Dr Dinger does not question that COCs containing LNG are at least as safe and efficacious as those containing one of the newer progestogens.

The basket of care offered by sexual health services is constantly changing. More than was the case in the past, we promote subdermal and intrauterine methods and offer sexually transmitted infection (STI) and HIV screening and manage genitl tract infection. To afford to do this we have to keep costs low. Where budgets are finite and probably shrinking, the cost of prescribing COCs containing a newer progestogen instead of LNG can be measured in fewer implants or intrauterine methods inserted and fewer chlamydia or HIV tests undertaken.

This is as good a reason as any to adhere to Faculty Guidance on First Prescription of Combined Oral Contraception, which states: “A monophasic COC containing 30 µg ethinyll estradiol with norethisterone or levonorgestrel is a suitable first pill (Grade C)”3.

Rudiger Pittrof, MD, MS
Consultant, Enfield Community Services, Reproductive and Sexual Health (RASH), London, UK.
E-mail: rudiger.pittrof@enfield.nhs.uk

Ulrike Sauer, MD
Specialist Registrar, Enfield Community Services, Reproductive and Sexual Health (RASH), London, UK.

References


Drosopirenone and VTE

Following publication in the October 2009 issue of the commentary article regarding the risk of venous thromboembolism (VTE) with combined oral contraceptives (OCs) and subsequent criticisms,1 we would like to share some information regarding prescribing in Zagreb, Croatia of a recently introduced OC, containing 3 mg drosopirenone and 30 µg ethinyll estradiol (DRSP/EE) (Yasmin®). We collected data in the city of Zagreb during the period 2004–2008, employing various data sources as follows: data on inpatients from Zagreb; data on the causes of hospitalisation data on side effects from the Agency for Drugs and Medicinal Products; and data on drug use from Zagreb pharmacies. The total female population under surveillance was 193,246.

In Zagreb, use of OCs in general increased by 31% between 2004 and 2008. This rising tendency was especially pronounced after 2005, when the combination DRSP/EE was introduced. In 2005, DRSP/EE accounted for 15.4% of the overall utilisation of OCs, which increased to 57.7% in 2008, yielding a 4.4-fold increase. Other OCs classified as fixed combinations of progestogens and estrogens showed a decrease in this period. In common with other OCs, in Zagreb DRSP/EE is issued on private prescription by pharmacists. OCs are usually prescribed by gynecologists, but may also be prescribed by other specialists.

The number of reported side effects of all drugs of any kind increased by 69.2% (i.e. from 993 in 2005 to 1680 in 2008). Annual trends in the rate of hospitalisation showed a significant tendency was especially pronounced after 2005, when the combination DRSP/EE was introduced. In 2005, DRSP/EE accounted for 15.4% of the overall utilisation of OCs, which increased to 57.7% in 2008, yielding a 4.4-fold increase. Other OCs classified as fixed combinations of progestogens and estrogens showed a decrease in this period. In common with other OCs, in Zagreb DRSP/EE is issued on private prescription by pharmacists. OCs are usually prescribed by gynecologists, but may also be prescribed by other specialists.

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