


7. Von Hertzen H, Piaggio G, Ding J, Chen J, Song S, Chen J, et al. Studies have also demonstrated that levonorgestrel (LNG). Biomedical studies have shown that 2. A Cochrane review actually concluded that mifepristone is better than levonorgestrel in preventing pregnancy when used for EC. 7. Cheng L, Gulemezzu AM, Piaggio G, Ezzurra E, van Look PF. Ulipristal acetate compared to levonorgestrel for emergency contraception within five days of unprotected intercourse: a randomized controlled trial. Abstract presented at the 8th Congress of the European Society of Gynaecology, Rome, Italy, 10–13 September 2009.


Letters to the editor

In response to the letter by Drs Pittrof, Rubenstein and Sauer we would like to make the following points:

1. The recent randomised controlled trial and meta-analysis of studies comparing UPA with LNG for emergency contraception (EC) that was published in the Lancet showed that UPA reduces the risk of pregnancy by almost one half compared to LNG.

2. A Cochrane review actually concluded that mifepristone and levonorgestrel (LNG) are more effective than levonorgestrel (LNG). Biomedical studies have shown that when given at mid-cycle (when risk of pregnancy is highest) LNG is able to delay ovulation whereas LNG is no better than placebo. 2. Studies have also demonstrated that LNG has endometrial effects (which may or may not contribute to efficacy) whereas LNG does not. 3. The recent randomised controlled trial and meta-analysis of studies comparing UPA with LNG for emergency contraception (EC) that was published in the Lancet showed that UPA reduces the risk of pregnancy by almost one half compared to LNG.

3. As regards the possible effect of UPA if taken after pregnancy has been confirmed, we observed in our study that there were pregnancies in women treated with UPA that were judged to have occurred well before treatment, that continued after UPA treatment. 6. Furthermore, the miscarriage rate in women who received UPA was similar to that in women who had LNG and no different from that observed in the general population of pregnant women. While there have been a small number of normal births in women who received UPA, clearly UPA is a new drug and so it is only appropriate that a European pregnancy registry has been established to collect more information on effect on ongoing pregnancy.

4. We discussed the possible interaction of a progesterone receptor modulator (PRM) with hormonal contraceptives in our commentary on this Journal 3 and concluded that further research is required, because the requirement to abstain or use barrier methods for the remainder of the menstrual cycle is not supported by the data.

5. Drs Pittrof, Rubenstein and Sauer express concern that women who cannot access National Health Service abortion services may try to procure UPA from alternative suppliers, as a result of the discussion of the data on emergency contraception. We believe that a study conducted over the Christmas period, when workload is not typical, for such a short period of time may not truly reflect patient flow. In fact the observed improvement may not be related to the change in process at all. Also, evaluating such a change is immediately unlikely to record the true effect of the change. Finally, in relation to the methods used in the study, the practice of discarding incomplete forms will introduce further bias and complicates the statistics.

In conclusion, we welcome a paper that aims to improve patient care and the offering of care, studying ways to reduce waiting time, but should guard against overenthusiastic claims.

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References