Letters to the editor

Menstrual cycle, convey concepts more dynamically than could ever be displayed on paper.

Video consultations... 58(6 Suppl.): 91S–97S.

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Replay

In her letter, Dr. Lee raises a pertinent question regarding the multiple risk factors for cardiovascular disease is now clearly stated. I would, however, prefer the definition for ‘older age’ to be stated. I would interpret this as being aged 35 years or over, but the additional comments at the end of the section imply the definition is aged 40 or above.

We fully appreciate that UKMEC is a guidance document and not a list of rules as such, but if these are too loosely presented then they will not serve their purpose in ensuring safe prescribing practice.

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References


Reply

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References


The rationale for these changes is partly explained in an article by Trussell et al. Obesity is generally perceived to be an important risk factor in CHC users because of the high relative risk of venous thromboembolism (VTE). Trussell argues that, in terms of absolute or attributable risk, other cardiovascular risk factors are more strongly associated with VTE and mortality than obesity. For example, the absolute risk of VTE in CHC users aged 45–49 years (UKMEC 2) is 175 per 100,000, which is greater than a VTE risk of 105 per 100,000 associated with CHC use and body mass index (BMI)≥35 (UKMEC 3). The risks in terms of deaths in CHC users are even lower, with an absolute risk of 3.3 deaths per 100,000 in smokers aged <15 years (UKMEC 2) and a risk of 0.6 deaths per 100,000 in women with BMI<35 (UKMEC 3).

With regard to the UKMEC 2009 section on multiple risk factors for cardiovascular disease, the text is unchanged from UKMEC 2005. The additional comments do appear to imply that the UKMEC definition of ‘older age’ is aged 40 years or above. Risk factors such as age are a continuum and there is not necessarily an exact cut-off. As Dr. Lee acknowledges, UKMEC is only a guidance document, and it would be entirely appropriate for clinicians to apply their own clinical judgement.

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References


The advice for using a hormone-only implant for women on long-term liver enzyme-inducing drugs is to continue using it together with additional contraceptive protection (such as condoms) and for 4 weeks after the drugs are stopped.

I do agree with the views expressed recently in our clinic, namely Implanon® failure in two women on antiretroviral (ARV) medication who did not report their use of Implanon®. The patient in the case report had an ectopic pregnancy. The majority of HIV-positive women are of reproductive age. Contraceptive options must take into account the risk of an unintended pregnancy, vertical transmission, and horizontal transmission for a non-infected partner. To achieve all these goals, a combined contraceptive (barrier method plus another method) is the ‘gold standard’. Some practitioners will argue that the ‘Double DUTCH’ advice should be given to all patients and not just HIV-positive women.

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References

