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

Video consultations demonstrate communication aspects. Links to referenced sites are well chosen and accessible. The interactive self-assessment is challenging and – dare I say – fun, and I learned from some errors but I will not confess where!

I think e-SRH e-Learning is good preparation for the Practical Sessions of the FSRR Diploma, and with regular updating it will provide a valuable educational resource for us all in the future. Congratulations to all the team involved with this project.

Michael Tapley, MBBCh, FFDP
Associate Specialist, Contraception and Sexual Health, Choices Centre@Town Central, Stockport, UK.
E-mail: m.tapley@btopenworld.com

References

Query about Faculty updated UKMEC
I would be grateful if the Faculty of Sexual and Reproductive Healthcare could explain why in the updated UK Medical Eligibility Criteria for Contraceptive Use (UKMEC 2009)1 the Category 4 for body mass index (BMI)40, has been removed? As a raised BMI is so closely associated with increased risk of venous thromboembolism, this does not seem logical. Without the Category 4 status, I am concerned that increasing numbers of patients with a BMI≥35 and indeed a BMI>40, will start, or continue to take, the combined pill, without any robust guidance to support this as a dangerous practice.

I am, however, pleased to see the Category 3/4 for 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 45 years or above. 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.

Louise Melvin, MRCOG, MFSSH
Director, FSRR Clinical Effectiveness Unit, and Consultant in Sexual and Reproductive Health, Sandford, Gloucs, UK.
E-mail: louise.melvin@nhs.net

References

Replay
In her letter, Dr Lee raises a pertinent question regarding the new UK Medical Eligibility Criteria for Contraceptive Use (UKMEC 2009)2 categories for body weight and combined hormonal contraception (CHC) use. The current Clinical Effectiveness Unit was not involved in updating UKMEC but we believe the body weight categories were made less restrictive to make them more consistent with the categories for other cardiovascular risk factors and CHC.

The rationale for these changes is partly explained in an article by Trussell et al.3 Obesity is generally perceived to be an important risk factor in CHC users because of the high relative risk of venous thromboembolism (VTE). The authors argue 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 of 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 <35 years (UKMEC 2) and a risk of 0.5 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.

Louise Melvin, MRCOG, MFSSH
Director, FSRR Clinical Effectiveness Unit, and Consultant in Sexual and Reproductive Health, Sandford, Gloucs, UK.
E-mail: louise.melvin@nhs.net

References

Implanon® failure in patients on antiretroviral medication: the importance of disclosure
We would like to draw other practitioners’ attention to the following case observed recently in our clinic, namely Implanon® failure in two women on antiretroviral (ARV) medication who failed to mention Implanon use to their HIV physicians.

The case highlights the unforeseen risks in terms of deaths in CHC users because of the high relative risk of VTE. The authors argue 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 of 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 <35 years (UKMEC 2) and a risk of 0.5 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.

Deborah J Lee, MBBCh, MRCGP
Associate Specialist in Reproductive Health, Lead Clinician CASH, Salisbury Department of Sexual Health, Salisbury, UK.
E-mail: Deborah.J.Lee@salisbury.nhs.uk

Reference

Nisha Lakhi, MD
Medical Student, Department of Obstetrics and Gynaecology, Brooklyn Hospital Center, Brooklyn, New York, NY, USA.
E-mail: nshlakhi@yahoo.com

Abha Govind, MFSSH, FRCOG
Consultant, Department of Obstetrics and Gynaecology, North Middlesex University Hospital, Edmonton, London, UK.
E-mail: Abha.Govind@mnh.nhs.uk

References