Contraceptive failure and the progesterogen-only pill

The case report by Chandler and Nash1 in this issue of the Journal is interesting and highlights the need for trials of hormonal contraceptive use to include obese women.

The authors acknowledge that despite an apparent association between contraceptive failure and higher body weight in studies of a Norplant® prototype and a levonorgestrel-releasing vaginal ring, there is insufficient evidence to demonstrate reduced efficacy in heavier women using the progesterogen-only pill (POP). Current guidance from the Faculty of Sexual and Reproductive Healthcare (FSRH)2 advises one progesterogen-only pill (POP) per day irrespective of body weight. This recommendation is based on the evidence available at the time of publication and the consensus of the guideline development group.

The recent review of obesity and oral contraceptive failure (OCF) failure by Trussell et al3 lends further support to FSRH guidance. The authors conclude that they “found no convincing evidence that very heavy or obese women have a higher risk of oral contraceptive pill [combined and progesterogen-only] failure during perfect use than thinner women, even with the lowest doses formulations”. Trussell and colleagues mention the difficulties of reliably measuring adherence and they speculate that OCs may be less forgiving of imperfect use among heavier women.

Given that long-acting reversible methods of contraception (LARC) are known to be highly effective and less dependent on adherence than OCs, LARC methods should be offered to all women, particularly following OCP failure.

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References

Lost IUD penetrating bladder wall

The incidence of uterine perforation following intrauterine device (IUD) insertion is reported to be approximately 1 per 1000 insertions.1 Misplaced IUDs can be diagnosed simply with speculum examination. Missing threads is the usual sign and may be due to unrecognized expulsion, enlarged uterus due to pregnancy, the IUD threads becoming occluded, or whether the IUD moved through the uterine wall during pregnancy. This case also demonstrates an uncommon localisation of an IUD and the close relationship between pelvic pain and IUD misplacement. This case also emphasises the need for regular check-ups following IUD insertion and the need to be suspicious of possible locations other than the uterus. Most importantly, an accurate diagnosis may facilitate the use of endoscopic techniques, and result in minimally invasive treatment.

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Lost IUD penetrating bladder wall

Figure 1 Cystoscopy and laparoscopy images. (A) Only one thread of the T-copper intrauterine device was found to be penetrating the bladder wall. (B, C) Extraction with forces resulted in the successful traction of the device except for the base and the threads. (D) Using a laparoscopic approach it was possible to extract the remainder of the device after minimal dissection.