Contraceptive failure and the postcoital-pill (POP)

The case report by Chandler and Nash 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 postcoital-only pill (POP). Current guidance from the Faculty of Sexual and Reproductive Healthcare (FSRH) advises one postcoital-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.

Recent review of obesity and oral contraceptive failure (OCF) failure by Trussell et al lends further support to FSRH guidance. The authors conclude that “there is no convincing evidence that very heavy or obese women have a higher risk of oral contraceptive pill [combined and postcoital-only] failure during perfect use than thinner women, even with the lowest doses formulations”. Trussell and colleagues mention the difficulties in 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 exceptionally low at 1/1000 insertions. Misplaced IUDs can be diagnosed simply with suprapubic examination. Missing threads is the usual sign and may be due to unrecognized expulsion, enlarged uterus due to pregnancy, the IUD threads becoming detached or, most importantly, whether the IUD moved through the uterine wall during pregnancy. This case also demonstrates an uncommon localization of an IUD and the close relationship between pelvic pain and IUD misplacement. This case also emphasizes 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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