Commentary on 'Prescribing patterns of combined hormonal products containing cyproterone acetate, levonorgestrel and drospirenone in the UK'

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The research undertaken by Cea-Soriano *et al*[1] provides for the first time analysis of the prescribing patterns of three combined hormonal contraception (CHC) products with regard to contraceptive and non-contraceptive indications. Their study utilised the general practice database, The Health Improvement Network (THIN), and considers the proportion of new and continuing users of these methods, along with the indications for their use, for the time period January 2002 to December 2010.

The three key insights from this article are, first, the identification that during the period of review the use of cyproterone-containing preparations solely for contraception has reduced from 32.9% in 2002 to 8.6% in 2010 with the majority of women in 2010 having been prescribed this medication for acne management. Second, that the use of both drospirenone (DRSP)- and levonorgestrel (LNG)-containing preparations for hormone-dependent conditions including menstrual disorders, acne, hirsutisms and other gynaecological conditions has increased from 30.4% in 2002 to 43.2% in 2010 for DRSP-containing CHC and from 24.3% in 2002 to 30.8% in 2010 for LNG-containing CHC. Third, the article clearly presents current prescribing practice for naïve (first-time users) and current or previous users. Within their research the authors identified that the majority of LNG users were naive in both 2002 (70.1%) and 2010 (74.3%) whereas a much smaller percentage of DRSP users were naïve in both 2002 (9.4%) and 2010 (19.2%).[1] This reflects national guidelines recommending the use of LNG- or norethisterone-containing CHC as first-line from both a safety and cost-effective standpoint.[2]

Although clearly a very useful article, as with all database studies there are some limitations. These are acknowledged by the authors and include the reliance on quality and accuracy of the completion of the dataset. In addition, it would have been useful to include more recent data and other combined hormonal preparations, as no clear indication was made as to the rationale behind only considering the three preparations selected. Furthermore, as it is a database analysis study it is not possible to determine if the patients included had received contraception previously from another source such as an integrated sexual health clinic, and it was not reported whether the prescription was initiated subsequent to a visit to a secondary care provider. However, this study clearly demonstrates an encouraging trend towards increased use of CHC for non-contraceptive indications.

A useful addition to this study would have been the inclusion of the adherence of prescribing to the *UK Medical Eligibility Criteria for Contraceptive Use* (UKMEC)[3] for those using these preparations for contraception only. In 2013 Briggs *et al*[4] determined a statistically significant reduction in the number of higher-risk users (women who were deemed to have a condition which is a UKMEC Category 3 or 4 for CHC use) from 2005 to 2010 following the publication of the UKMEC in 2006. Given that different databases [THIN and GPRD (General Practice Research Database)] were utilised, this study would have provided an opportunity for comparison. Furthermore, if more recent data had been included in the current study then the impact of UKMEC 2009[5] could have been considered.

This article also provides the opportunity to highlight the importance of informing patients that the medication they are being prescribed is outside the product's licence (i.e. off-licence or unlicensed). The General Medical Council[6] advises that unlicensed medications may be used following patient assessment when clinicians have determined that patients' needs can be best met medically by means of this course of action. Generally, patients should be made aware that they are being prescribed an unlicensed medication, and be advised about the risks and benefits of the medication to enable them to make an informed decision regarding its use. Furthermore, when use is recommended by national or international guidelines it is beneficial to discuss this with patients.

Overall, this article provides a valuable baseline for future research and useful insight into recent changes to prescribing for both contraceptive and non-contraceptive indications. Further research that considers the use of other methods of contraception for non-contraceptive reasons and assesses the impact of UKMEC 2009[5] and subsequently UKMEC 2016[7] on contraception prescribing would be valuable additions to this area of research.

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