Letters

LETTERS

Nova T® 380 and levonorgestrel IUS studies

Madam,

The UK Family Planning and Reproductive Health Care Network have recently completed 5 year studies on these two devices, and following Dr Bacon’s letter1 we thought it may be useful to give the 24 month results of these studies (Table 1), which have now been published elsewhere.2,3

Table 1 Cumulative life-table gross closure rates at 24 months

<table>
<thead>
<tr>
<th>Nova T® 380</th>
<th>Levonorgestrel</th>
<th>IUS</th>
</tr>
</thead>
<tbody>
<tr>
<td>N</td>
<td>572</td>
<td>692</td>
</tr>
<tr>
<td>Pregnancy</td>
<td>1.9</td>
<td>1.1</td>
</tr>
<tr>
<td>Expulsions</td>
<td>9.1</td>
<td>5.3</td>
</tr>
<tr>
<td>Removal for bleeding problems</td>
<td>17.8</td>
<td>11.9</td>
</tr>
<tr>
<td>Pelvic inflammatory disease</td>
<td>1.0</td>
<td>1.1</td>
</tr>
<tr>
<td>Removal to plan pregnancy</td>
<td>8.3</td>
<td>8.2</td>
</tr>
</tbody>
</table>

In the Nova T® 380 study there were seven pregnancies, of which one had a normal delivery. Three were terminated, one had a spontaneous abortion, and two were ectopic. In the levonorgestrel IUS study there were five pregnancies, of which one had a normal delivery. Two were terminated, one had a spontaneous abortion, and two were ectopic. It is our intention to publish the 5 year results during 2001.

Sue Richardson, Chair; Michael Cox, Lead Investigator Institute of Population Studies, School of Postgraduate Medicine and Health Sciences, University of Exeter, 101 Pennsylvania Road, Exeter, EX4 6DT, UK.

References

What indeed is so bad about teenage pregnancy?

Madam,

First we have to ask what is meant by the term ‘teenage pregnancy’ and, indeed, what statistics are gathered regarding teenage pregnancy.

The papers reviewed in this article4 seem to show adverse outcomes mainly below 16 years of age.

If the term ‘teenage pregnancy’ includes planned pregnancy in 17-19 year old mothers in stable relationships, then many of these are not a major social and medical problem. If the term is restricted to unplanned pregnancies in the teenage years or only pregnancies under the age of 16 years, then I agree that many of these do reflect a major social and medical problem.

I believe more clarity is needed about what exactly the term ‘teenage pregnancy’ really means. If nationally we are collecting statistics that record both high and low risk groups, then they are of very little use in planning local services or allocating resources.

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Reference

Pre-menarchal prescription of Dianette

Madam,

Standard recommendation is that the combined pill should not be started until after the menarche, since there is a lack of evidence as to the effect an earlier start might have on the pituitary-ovarian axis.

I have just seen a 16-year-old girl in the family planning clinic who was started on Dianette at age 12, before her menarche, because of a spotty face. She continued taking it until she was 14.5 years old, and stopped when she changed to tetracycline therapy. She reports no delay in the continuation of regular menstruations, although they were heavier, without period pain. She attended our clinic at age 15 years and 10 months, weight 50 kg, and was started on the combined pill.

I report this to show that, for one young woman of normal weight, menarche proceeded apparently normally despite therapeutic suppression of ovulation.

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Which intra-uterine device should we favour?

Madam,

In common with other family planning doctors with their clients’ best interests at heart, I am keen to make an intelligent and informed decision as to which IUDs are reasonable and efficient alternatives to the Gyne T 380 which we believed to have a superior failure rate compared to the other available copper devices. I was therefore interested to read the report on the Nova T 380 from the UK Family Planning Research Network in the July 2000 issue, which reported a favourable low failure rate of 0-8 per 100 woman-years at 1 year. The report also quoted seven other studies to provide comparisons between the failure rates of the Nova T(200), Nova T 380 and the Gyne T 380 online. In this context, it might help to compare the devices with regard to failure rate.

However, on close study of these papers and a Medline literature search on other IUDs I have come to the conclusion that far from the published data allowing us to ‘rank’ the available devices, they generally show us no statistically significant differences in the failure rates. A serious omission from the tables in this paper (and others in our Journal) are the probability levels that the results quoted achieve statistical significance. In fact these, and many other studies on IUDs, were on sample sizes of 200-1116 women with event rates (i.e. unintended pregnancies) so small that a very wide variation between different studies of identical devices. For instance, one study of the much maligned Nova T 200 had the lowest failure rate of all the quoted studies with no failures in one year (in a sample size of 438 women), which was from our own UK Family Planning Research Network study published in 1989. As recently as 1995 Farr et al reported a comparative study of the Copper T 380A and the Lippes Loop,1 giving a failure rate of 2.1 for the Lippes Loop and a potentially impressively low rate for the Copper T 380A of 0.7, but with wide variation in the sample size of 710. It may arise. This may be due to the relative affluence of the population of York. But the prevention of pregnancy was poor.

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Reference

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References

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Sue Richardson and Michael Cox

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