Evidence-based reproductive medicine

Madam

I look forward to the arrival of the Journal. It is always a good read, full of relevant and practical information – much more ‘user-friendly’ than most journals I receive these days. July’s edition seems particularly interesting with a number of interesting articles.

However, my interest was quickly replaced by irritation. There is a lot to be said for evidence-based medicine (EBM), it is always helpful to have a review of the current evidence available in order to provide women with accurate information when discussing contraception. However, it is not sufficient just to provide the ‘evidence’. EBM must consider that clinicians need practical guidance with decision making.

The Clinical Effectiveness Unit (CEU) produces reviews of the evidence-based medicine (EBM) for the Clinical Effectiveness Unit (CEU). It states: ‘an evidence-based recommendation cannot be made that the desogestrel-only pill is different from other POPs in terms of efficacy, nor that it is similar to combined oral contraception (COC) in this respect.’

The recommendation is based on insufficient evidence to support lower failure rates with the desogestrel pill. This is despite another study showing that the desogestrel-only pill was sufficient to inhibit ovulation in 97% of cycles and that this is its primary mode of action. Furthermore, the data provided by the manufacturers may not be credible raises an additional concern. In the same edition an excellent article on evidence-based reproductive health by Lynn Davis quotes a Chinese proverb: ‘Be careful what you wish for: it may come true.’

The author adds that pharmaceutical industry-funded trials tend to report more favourable findings than those funded by other means, noting that one of the trial authors for the desogestrel-only pill studies is affiliated to the company that manufactures the pill. If this is an issue, then we need practical guidance with decision making.

The Collaborative Multicentre Bleeding Pattern and Efficacy trial (CMBPE) provides an utterly objective summary of current evidence concerning the desogestrel pill. I stand by my statement that ‘on theoretical grounds we regard the desogestrel pill to be more effective than existing progestogen-only pills ... but we do not have trial evidence to support this’. The evidence-based reproductive health paper by Foyle et al. is commended by your first correspondent but reaches the same conclusion as our New Product Review: ‘You cannot tell if the DSG pill is superior to inferior to other POPs’.

Dr MacGregor mentions ‘the suggestion that the data provided by the manufacturers may not be credible’. Nowhere in our New Product Review is an independent or suggestion made relating to claims or data provided by the manufacturers. She goes on to seek assurance ‘that none of those undertaking the desogestrel-only pill review have any relevant associations with manufacturers of other progestogen-only pills’.

The New Product Review from the CEU does not include an explicit statement of interests. However, the CEU states that ‘the recommendations are made by a formal code of practice on ‘Relationships with the Pharmaceutical Industry’, which was drawn up in consultation with the FFPCHR Clinical Effectiveness Committee. She feels that we have misrepresented ‘Category 3’ (risks outweigh the benefits) as ‘Category 3 – risks outweigh the benefits’. I am concerned that the CEU is perpetuating this misinterpretation of the WHO 3 category that does not absolutely contraindicate use, although other methods should be the first choice.

Anne MacGregor, MFFP
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References

CEU New Product Review of the desogestrel-only pill

Madam

The Clinical Effectiveness Unit (CEU)’s product review of the desogestrel-only pill’ and the recent article ‘Is Cerazette the minipill of choice?’ in the Drug and Therapeutics Bulletin (DTB) are both good reviews of available studies. But in my opinion they are marred by their surprisingly negative conclusions.

What do we do when we evidence from clinical trials and epidemiology is not as complete as we would all like, but we have clients sitting in front of us wanting our help in choosing from the available options? It is then not sufficient just to provide the ‘evidence’ from an ivory tower. A decision has to be made, at time present. Pending more data, evidence-based medicine (EBM) must be subjected to informed clinical judgement, based on all available evidence (including the reported pharmacology of the product) and – dare I say it? – clinical common sense.

The statement of the DTB is inaccurate when it states ‘desogestrel only pills as words as the CEU?’ ‘There is insufficient evidence on whether it (Cerazette) is a more effective contraceptive than other POPs in terms of efficacy’. The evidence based reproductive health paper by Foyle et al. is commended by your first correspondent but reaches the same conclusion as our New Product Review: ‘You cannot tell if the DSG pill is superior to inferior to other POPs’.

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References

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Reply

Madam

On behalf of the FFPCHR Clinical Effectiveness Unit (CEU), I thank you for the opportunity to respond to the letter from Anne MacGregor concerning two articles in the July 2003 issue of the Journal relating to the desogestrel-only pill. I am sorry that your correspondent found the New Product Review from our Unit irritating, rather than clinically useful.

We also welcome the opportunity to respond to the letter from John Guillebaud on the same theme.

In my view, our New Product Review provides an utterly objective summary of currently available evidence concerning the desogestrel pill. I stand by my statements that ‘on theoretical grounds we regard the desogestrel pill to be more effective than existing progestogen-only pills ... but we do not have trial evidence to support this’. The evidence-based reproductive health paper by Foyle et al is commended by your first correspondent but reaches the same conclusion as our New Product Review: ‘You cannot tell if the DSG pill is superior or inferior to other POPs’.

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References
I trust that your readers can be reassured that the CEU is committed to providing objective summaries of available evidence as a service to Faculty members. Our documented code of practice precludes any relationships with pharmaceutical companies that might represent conflicting interests in our product reviews. In line with established principles of evidence-based medicine, we do not make clinical practice recommendations based on assumptions, personal beliefs or inappropriate extrapolations from research data. On this basis, we stand by our published conclusions and recommendations regarding the desogestrel pill.

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References


New GyneFix® introducer

Madam

We wish to share our experience with the use of the new GyneFix® introducer. The Abacus Centre in Liverpool was the first service to offer the frameless intrauterine device, GyneFix in the UK, when it was introduced in 1997. To date we have fitted 1750 of these devices. Our audit of the first 100 insertions showed we had 11 failed insertions (of the 1000). Since the introduction of the new GyneFix introducer in our service and after we made repeated reports of failed insertion by all doctors carrying out insertions in our service. Initially we considered this to be part of the learning curve with the introduction of the new device. However, when the failed insertions continued, we undertook an audit of failed GyneFix insertions from January 2003 to August 2003. During this period there were 50 attempted GyneFix insertions of which 38 were successful and 12 failed to anchor the device. In 7/8 successful insertions, there was more than one attempt to implant the GyneFix. We wasted 18 devices during the 50 attempted insertions. There was no indication that doctors with greater experience in GyneFix fitting had fewer failed insertions compared to those who had fitted fewer devices. This has raised difficulties in our counselling of women for GyneFix insertions as well as in our ability to continue to offer it as part of our contraceptive menu. We have reported these failed insertions to the manufacturer. We have heard from them that they have decreased the thickness of the introducer tip which may reduce this problem. However, this modification is only in the GyneFix 200, which only has four beads and for which there are few published long-term data.

We will be very interested to hear from other services as to whether they are experiencing similar problems with the new GyneFix introducer.

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Changes to cervical cytology screening

Liquid-based cytology will now be the preferred method of examination. In this method of screening the sample is collected from the cervix in the same way, but using a special plastic broom-like device which is swept over the transitional zone five times to collect cellular material. The broom is rinsed or broken off in a vial of preservative. The vial is mixed in the laboratory and treated to remove unwanted material by an automated process. The remaining suspension is then centrifuged, the supernatant is discarded and the prepared slide looks much clearer for examination. The number of unsatisfactory (inadequate) slides is reduced and fewer women will be made liable to further attendance. The frequency of screening will also be changed to a more equitable system. All women, wherever they live, are to be screened every 3 years from the age of 25–49 years and then every 5 years until the age of 64 years. Further information is available at www.nice.org.uk.

Male contraception

Health professionals may have been perplexed by reports in the media about ‘The risk-free pill for men’ (Daily Mail) or ‘Male birth control pill successfully tested’ (The Daily Telegraph). These newspapers had picked up on a report from Australia that showed no pregnancies in the partners by the end of 12 months. The men received an injection of 150 mg depot medroxyprogesterone acetate together with an implant of 800 mg testosterone every 4 months. No serious side effects such as weight gain or hypertension were recorded in the 55 men studied. All male methods requiring sperm suppression have a long lead-in period, of course. It will be interesting to see if larger studies are as free from problems, such as mood swings or loss of libido, as the limited previous studies of this combination of therapies. Further information on male contraception is available from www.malecontraceptives.org.

Four periods a year

Seasonale® has been approved by the Food and Drug Administration in the USA. It contains levonorgestrel and ethinyl oestradiol and is taken consecutively for 84 days, followed by seven pill-free days to produce a withdrawal bleed. Trials showed a similar effectiveness to conventional combined oral contraceptives. Some of the comment surrounding this alternative has suggested that it is healthier to avoid menstrual loss, a statement that cannot be backed by evidence at present. Making Seasonale available will expand women’s contraceptive options and increase convenience for some. This advance should not be undermined, however, by over-promising and over-promotion or by stigmatising women who choose alternative methods. More information is available from www.womenshealthnetwork.org.

Reviewed by Gill Wakley, MD, MFFP
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CEU New Product Review of the desogestrel-only pill

John Guillebaud

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Updated information and services can be found at:
http://jfprhc.bmj.com/content/30/1/64.2.citation

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