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 competing 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.

Gillian Penny, FRCOG, MFFP
Honorary Director, Clinical Effectiveness Unit, Faculty of Family Planning and Reproductive Care, Aberdeen Maternity Hospital, Cornhill Road, Aberdeen AB25 2ZD, UK

References

New GyneFix® introducer

Madam

We wish to share our experience with 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 in May 2003, we have anecdotal 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 widely used inserter. 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 inserter tail, 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.

Andrea Brockmeyer, MRCOG, DFFP
Subspecialty Trainee; State Exam Med Tubingen/Germany, Abac Bus Clinics for Contraception and Reproductive Health Care, Liverpool, UK

... and other new products.

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 sample is rinsed or broken off a vial of preservative. The vial is mixed in the laboratory and treated to unwanted material by an automated process. The remaining suspension is centrifuged and the prepared slide looks much clearer for examination. The number of unsatisfactory (inadequate) slides is reduced and fewer women will be made anxious by being recalled.

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, 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

Seasonal® has been approved by the Food and Drug Administration in the USA. It contains levonorgestrel and etinodiol diacetate 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 Seasonal available will expand women’s contraceptive options and increase convenience for some. This advance should not be undermined, however, by over-promising or over-promotion or by stigmatising those who choose not to use it. More information is available from www.womenshealthnetwork.org.

Reviewed by Gill Wakley, MD, MFFP
Visiting Professor in Primary Care Development, Staffordshire University and Freelance General Practitioner and Writer, Abergavenny, UK and P S Aranikamudi, MD, MRCOG
Specialist Registrar in Obstetrics and Gynaecology, Rosie Maternity Hospital, Cambridge, UK

Meera Kishen, DGO, Dip Gyn, MFFP
Consultant in Family Planning and Reproductive Health Care, Abacus Clinics for Contraception and Reproductive Health Care, Liverpool, UK

Anne Webb, MRCOG, MFFP
Consultant in Family Planning and Reproductive Health Care, Abacus Clinics for Contraception and Reproductive Health Care, 40–46 Dale Street, Liverpool L2 5SF, UK

Dieting and breakthrough bleeding on COCs

Madam

When dealing with the Margaret Pyke postbag, I was interested to read a number of requests asking for advice on the development of breakthrough bleeding (BTB) on combined oral contraceptives (COCs) in women who had a regular bleeding pattern until they went on diets and lost a lot of weight quite quickly. In one case, the Atkins diet (high protein, low carbohydrate) had been followed; in another, the woman was using Lighter Life® meal replacements. All other causes of BTB had been excluded.

I would be interested to know if other readers have come across this phenomenon and if so, should ask a question about dieting and weight loss to my list for women who present with BTB.

Anne MacGregor, MFFP
Medical Adviser, Margaret Pyke Memorial Trust, 73 Charlotte Street, London W1T 4PL, UK