
There are more than 80 types of human papillomavirus (HPV) and approximately 30 strains are associated with genital infection. Several of the strains can be associated with cervical neoplasia. Evidence is accumulating to show that detection of persistent HPV could help detect those at most risk of cervical neoplasia disease progression.

This study looked at the diversity of HPV infection and its association with cervical neoplasia. It used 3444 randomly selected samples, which were residual from liquid-based cytology samples. Its aim was to investigate the overall prevalence of HPV, the type specific prevalence, and the number with multiple infections. This was then compared with the cytological assessment for neoplasia.

Approximately 10% of the samples showed some HPV infection. Overall, HPV was detected in 20% of samples, and 77% of these showed a high-risk type of HPV. Surprisingly, 3.4% of negative sample and in 33.3%, 41.8% and 40.4% of samples with borderline, mild or high-severity of dyskaryosis on cervical sample there showed a high-risk type of HPV. It has to be remembered that this is purely a hypothetical calculation as we all know women who fall outside the standard criteria as described above. Until the variables set by all contraceptive users are fully addressed, it is likely that any calculations can only give a rough estimate of the cost-effectiveness of a particular method.

Reviewed by Judy Murty, MRCP, MFFP

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This is another report derived from the data acquired during a Family Planning Association (Ipa) Study. Readers will remember that the study recruited around 17 000 married women between the ages of 25 and 39 years, from 17 family planning clinics between 1968 and 1974, who used oral contraceptives (OCs), a diaphragm or an intrauterine device. By the end of December 2000, 889 women had died.

The study found no overall increased risk of death from all causes among women who used OCs (regardless of duration of pill use) compared with women in the study who had never used OCs. Although the data suggested that the overall risk of death was higher among OC users than among non-users, this did not quite reach statistical significance.

In comparison with non-smokers, light smokers showed a slightly increased death rate from all causes of around 25%, and heavy smokers (women who smoked more than 15 cigarettes a day) showed more than a doubling of death risk from all causes. Even in women aged 25–44, the harmful effects of smoking were already apparent.

The study provided no surprises in reporting that in users of OCs compared with non-users, there was a decrease in mortality from uterine and ovarian cancers. The only increase in cervical cancer mortality. The numbers are all small with wide confidence intervals. Although women who took OCs and did not smoke, or only smoked lightly, showed no increased mortality from ischaemic heart disease, women who took OCs and smoked heavily showed a slightly increased death rate. The study did not show any relationship between length of OC use, age of OC start and risk of cancer mortality, nor between smoking and breast cancer mortality. These figures need to be considered together with the knowledge that this study did not recruit young women starting OCs before the first full-term pregnancy and that only 16% of the total number of women who died had recent or current exposure to OCs. A large number of other causes of death were examined, and the relationships to smoking and OC use. This is useful information if you need to discuss specific risks with an individual woman.

The Oxford Ipa Study is one of only three large-scale studies of long-term OC safety. It provides valuable data on the long-term effects of contraceptive use as well as morbidity and mortality among women of childbearing age. It does have some limitations. Long-term studies are subject to confounding factors and numbers dwindle. The numbers of deaths from any cause in this age group is (thankfully) small. Most of the OCs used in the 1970s and early 1980s contained ethinylestradiol. It is unclear whether the findings can be extrapolated to the pills in use currently. Also, some effects of OCs (e.g. on cardiovascular disease or breast cancer) have been shown to apply mainly to current or very recent users, OCs have been stopped when serious illness occurs, but death may not occur for many years. The analysis of the effects of smoking only considered the amount recorded at recruitment (93% of users were light smokers and 14% were heavy smokers).

The headlines in the news should have been: ‘Oral contraceptive use not harmful’. But, as usual, good news is no news. What did we not hear was either the bad news: ‘Young women are killed by smoking’. This is an important study reporting the harmful effects of smoking on the health of young and middle-aged women. All who work in contraceptive care are in contact with healthy individuals who might otherwise not see a health professional. Our primary task is to help them with their contraceptive needs, but we also have a responsibility to tell them about activities damaging to their future health.

Reviewed by Gill Wakley, MD, MFFP

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This paper is the fourth paper in this recent series that has suggested that hormonal emergency contraception (EC) can be used on the fourth or fifth day after unprotected sexual intercourse (UPS). This paper cites an imaginary woman who reported 4 days after UPSI. The author recommends that progesterone only (POEC) be prescribed. This is justified by reference to clinical studies, in which hormonal EC on the fourth and fifth days appeared to be effective. It will be relevant to look to the other three papers.

The first paper described POEC given to 131 women before 72 hours after UPSI compared to POEC given to 169 women between 72 and 120 hours after UPSI. The pregnancy rates were respectively 0.8% and 1.8%.

The authors concluded that POEC could be given up to 120 hours after UPSI. The second paper was the World Health Organization (WHO) study previously reviewed by you. The large-scale study of the pregnancy rates on Days 4 and 5 after UPSI were 1.1% and 4.8%, respectively. The mifepristone pregnancy rates on Days 4 and 5, respectively, were 1.0% and 5.1%.

The authors stated that the small numbers of women given delayed treatments in this trial makes our estimation very imprecise. The third paper compared 675 women who had Yuzpe regime EC within 72 hours with 111 who had Yuzpe regime EC between 72 and 120 hours after UPSI. The users were put into two groups: perfect users and typical users. The pregnancy rates on Days 4 and 5 were respectively 1.9% and 3.6%.

The authors concluded that Yuzpe regime EC could be given up to 120 hours after UPSI especially if an IUD was immediately inserted (POEC) or if perhaps the evidence is building in favour of extending the 72-hour limit. Although numbers are limited it is interesting that the highest pregnancy rates in the WHO study did not occur till the fifth day with low rates of pregnancy suggesting that the best limit may turn out to be 96 hours. Meanwhile, the official Faculty of Family Planning and Reproductive Health Care advice is that the limit should be 72 hours.

References


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Mortality in relation to oral contraceptive use and cigarette smoking

Gill Wakley

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