Evidence-based medicine and guidelines

Madam

I feel it necessary to join the discussion about evidence-based medicine (EBM) and guidelines. I am dismayed by the constant negative attitude towards new contraceptives that are being marketed. I do not believe (serious safety issues aside) that contraceptives should be viewed in entirely the same light as drugs used for a medicinal purpose; in the latter some minor adverse side effects are tolerated provided the overall risk/benefit balance is acceptable for the condition being treated. With contraception, both efficacy and minor side effects are equally important. Indeed, for some women, the balance is reversed with a poorer efficacy being tolerated in favour of lesser or more acceptable side effects.

The proponents of EBM have lost sight of the fact that most of what we do in family planning is not based on EBM at all but on the experience and knowledge of the individual health professional. To cite an example, the evidence-based recommendation cannot be made that the desogestrel pill is different from other POPs in terms of efficacy ... , while the Drug and Therapeutics Bulletin went further: ... there is insufficient evidence on whether it is a more effective contraceptive than other POPs and ... we believe the company’s claim that Cerazette has the ‘efficacy of a combined pill’ is unsubstantiated and should be withdrawn. Less than a year later, the product licence for Cerazette has been officially altered to allow a 12-hour pill-taking regime – the same as for the combined pill. To most of us, this had been obvious from the start: while acknowledging a lack of good evidence, why could those writing the product reviews not have been sadder, more willing to use a little common sense? Similar attacks have been made on both Evra® and Yasmin®, which should be on both Evra® and Yasmin®, which should be the same pay as nurses who have developed themselves and appear to be working harder.

Fourth, a nurse who has been developed in the workplace by a particular service may find it difficult to transfer these skills if she gets a family planning job in another service, and the new employer is obliged to provide repeat ‘in-house’ training and assessment because the nurse does not have a nationally recognised qualification. This can be difficult and confusing for nurses who work simultaneously for two or three different family planning services in their area, because Patient Group Directions (PGDs) are independently produced by each service with varying levels of freedom for nurse supply and administration of drugs. It is not common practice for nurses to issue prescriptions to clients in family planning clinics, as supplies are normally available to give out or administer on site.

These problems cannot be solved by doctors and managers alone; there needs to be a national plan for the introduction of modernised family planning training standards and practise, ideally driven by liaison between the NMC, the Faculty of Family Planning and Reproductive Health Care and the British Association for Sexual Health and HIV, to ensure that basic training for family planning nurses covers all aspects of care included in Level 1 of the national sexual health strategy. The syllabus should include the understanding and use of PGDs and the practical sessions should result in the nurse being able to work to PGDs. There should also be time devoted to attendance at governance, pregnancy termination and colposcopy clinics as standard. There ought to be nationally agreed PGDs for all contraceptive methods and drugs used for treatment of sexually transmitted infections, which would save the immense amount of time and effort which is expended in producing individual PGDs for each Trust or service in the country. This would be an excellent move forward. Perhaps the sexual health leads within strategic health authorities could be asked to take these ideas forward for national debate and co-ordination with the Nursing and Midwifery Council.

Pam Campbell, MSc, RGN
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Reference

Missing IUD fragment

Madam

The case report of Nadir et al.1 recommends that if a small fragment of an intrauterine contraceptive device (IUD) is found to be missing and cannot be retrieved by hysteroscopy or laparoscopy then laparotomy is necessary. This advice is neither pragmatic nor evidence based. The chances of finding a small portion of an IUD at laparotomy are remote and would require an extensive midline incision. The subsequent morbidity (adhesion formation, subacute obstruction, etc) considerably outweighs a theoretical risk of proliferative perforation, which even in the unlikely event of it occurring, is not likely to cause a major degree of peritonitis.

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Reference

Letters

3 Cerazette. (UK SmPC 03 Cera v1.3).

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References

Role of nurses

Madam

The Nursing Focus article by Pam Campbell in the July 2004 edition of the Journal raised the important issue of the enhanced nurse role, which is not being fully utilised in many areas of family planning. The barriers to implementing this role for nurses are not fully utilised in many areas. Unfortunately, the on both Evra® and Yasmin®, which should be taking leeway3 – the same as for the combined pill. Cerazette has the ‘efficacy of a combined pill’ is ... , while the Drug and Therapeutics Bulletin should learn from how people use its sister publication Which? When I want to buy a washing machine, I might not choose their evidence-based top product if it doesn’t match my kitchen, however well it washes my clothes.

First, it is extremely difficult to find extra ... the company’s claim that Cerazette has the ‘efficacy of a combined pill’ is unsubstantiated and should be withdrawn. Less than a year later, the product licence for Cerazette has been officially altered to allow a 12-hour pill-taking regime – the same as for the combined pill. To most of us, this had been obvious from the start: while acknowledging a lack of good evidence, why could those writing the product reviews not have been sadder, more willing to use a little common sense? Similar attacks have been made on both Evra® and Yasmin®, which should be on both Evra® and Yasmin®, which should be the same pay as nurses who have developed themselves and appear to be working harder.

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