New prescribing information for the desogestrel oral contraceptive
Following new evidence, the prescribing information for the desogestrel oral contraceptive (Cerazette®) has been changed. One of the disadvantages of progestogen-only pills (POPs) compared with combined oral contraceptives (COCs) has been the need to take it at the same time each day, with only 3 hours ‘forgetting time’. Now a study has confirmed that forgetting this desogestrel pill for 12 hours is not related to ovulation.1 In a study of women with confirmed previous ovulation, 103 women took Cerazette for 56 days and 12 hours late on three scheduled occasions. Only one ovulated (measured by alternate day progesterone P levels). That episode was not temporally related to late taking of the pill. The minimum time to post-treatment ovulation was 7 days with an average of 17.2 days from the last tablet taken to ovulation. So now you can give people taking the desogestrel POP the same information as you have done for COCs – if the missed pill is remembered and taken within 12 hours, no additional contraceptive precautions are required.

Reference

Anaphylactic shock and DMPA
Depot medroxyprogesterone acetate (DMPA) is thought to be very safe. Occasionally serious and potentially life-threatening adverse effects can occur. This case study reports a 40-year-old woman who went into anaphylactic shock after receiving 150 mg DMPA intramuscularly. She was not taking any other medication, and there was no history of allergy to food or cosmetics. She responded fully to immediate resuscitation. A repeat episode occurred when she received another dose 12 weeks later (I would not have risked it). Life-threatening adverse effects can occur with administration of any medication and clinicians should be prepared for such an eventuality.

Reference

Condom express
The Swedish Organisation for Sexual Education has launched a service to provide emergency condoms to those in desperate need. Using the name Cho-San Express, the organisation will have four cars loaded with condoms patrolling the streets of the capital, Stockholm, along with a pair of vehicles each in Goteborg and Malmoe, Sweden’s second and third largest cities, respectively. The express will deliver a pack of 10 condoms for slightly less than is charged at a state-owned pharmacy. The organisation hopes to ‘reach young people with a humorous twinkle in their eye’. They hope that the contraceptive will be seen as a fun sex accessory and not just as a way to protect against STIs. The initiative follows similar increases in STIs to those seen in the UK. Further information is available at http://ippsnet.ippf.org/pub/IPPF_News/News_Details.asp?ID=3503.

Collated and reported by Gill Wakeley, MD, MFFP
Visiting Professor in Primary Care Development, Staffordshire University and Freelance General Practitioner, Writer and Lecturer, Abergavenny, UK


Pregnancies that result in a birth are known to reduce a woman’s risk of breast cancer, but the effect of pregnancies that end as an abortion is less clear. Evidence from retrospective studies has been difficult to interpret because women have a tendency to under-report both spontaneous and, particularly, induced abortion, whereas women diagnosed with breast cancer may be more likely to disclose this information.

The authors of this paper reviewed worldwide evidence and analysed the results from prospective and retrospective studies separately. Among women with a prospective record of having had one or more induced abortions, there was no statistically significant difference between the breast cancer risk in those having more than one induced abortion (22 cases) and that in women with no induced abortions. In contrast, for women with a retrospective record of having had an induced abortion, breast cancer risk was significantly increased compared with women with no history of abortion (RR 1.20; 95% CI 1.00 to 1.44).

Reference
abortion, the relative risk of breast cancer was 0.93 (95% CI 0.89-0.96), compared with women who had never had an induced abortion. The corresponding relative risk for spontaneous abortion was 0.98 (95% CI 0.92-1.03).

In contrast to the findings of many retrospective studies, the prospective study suggests that induced or spontaneous abortions do not increase a woman’s risk of breast cancer.

Reviewed by Louise Melvin, MRCOG
Clinical Research Fellow, Royal Infirmary of Edinburgh, Edinburgh, UK

Effects of conjugated equine estrogen in postmenopausal women with hysterectomy. The Women’s Health Initiative Randomised Controlled Trial. JAMA 2004: 291: 1701–1712

This study was one of two parallel, randomised, double-blind, placebo-controlled trials designed to test the effects of this type of hormone replacement therapy (HRT) on chronic disease. The National Heart, Lung and Blood Institute in the USA set the study up 13 years ago. The oestrogen plus progestogen arm of the trial was halted in July 2002 due to increased risk of coronary heart disease, thromboembolic disease and breast cancer. This arm of the trial compared use of oestrogen only HRT (conjugated equine oestrogen) with placebo in nearly 11 000 women aged 50–79 years. The study was stopped a year before its scheduled conclusion, even though no predefined boundaries had been crossed. There was also a high degree of non-compliance: 50% by the seventh year. The study provides some important information. The treatment group had a 39% increased risk of stroke compared to the non-treatment group (44 vs 32 per 10 000 person-years). Contributing factors may have been the small but persistent increase in blood pressure and the known effect of oestrogen on increasing the risk of thrombosis. There was a reduction in low-density lipoproteins (LDLs) and an increase in high-density lipoproteins (HDLs) but no impact on coronary heart disease incidence. Oestrogen reduced the risk of fractures by 30% to 39% (11 vs 17 per 10 000 person-years) in the treatment group. They reported a lower rate of breast cancer in the treatment group compared to placebo. This particular result is contrary to the oestrogen plus progestogen arm of the Women’s Health Initiative (WHI) trial and clearly needs further investigation. The small numbers may have confounded the results. Two components of the WHI on the effects of a low-fat eating pattern, and the effects of calcium and vitamin D supplements are still awaiting publication. For the present time, this study contributes further weight to the advice that HRT should be used for short-term relief of vasomotor symptoms only.

Reviewed by Laura Patterson, MRCGP, FFPM
GP Non-Principal and Associate Specialist in Family Planning, Swindon, UK


This is a community intervention study designed to determine whether offering advanced supplies of emergency contraception (EC) to large numbers of women influenced the abortion rates. In one area of Scotland women between 16 and 29 years were targeted through health services to be allowed to take home five courses of EC to keep when needed. There were 85 000 women in the target age group of whom 17 800 took a supply of EC home. Some 45% of this group took at least one full course of the EC provided. The authors state that they have low abortion numbers in the intervention area (<2000 per year of the target group) and also reported that they had a high uptake of contraception in the area but numbers are not given. The results of the intervention did not reduce the abortion rate when compared with other areas of Scotland with no intervention.

In their discussion the authors did not emphasise that the EC used was Schering PC4 which is now not available. Levonelle® is now prescribed as it has been shown to be more effective but by how much is debatable. If the area targeted had a high uptake of contraception use then women probably were not aware of their pregnancy risks when using other methods so did not use EC when necessary. This study shows that no matter what we do as clinicians, we cannot predict what contraceptive users will do and how competently they can recognise when they are at risk of pregnancy.

The study raises concerns that sexually active young people are given messages that EC is available if they have pregnancy risk but this study may indicate that by making EC readily available this will still not impact on the abortion figures. Abortion figures will only reduce when the sexually active population are persuaded to use more effective long-term methods of contraception where EC is rarely needed.

Reviewed by Judy Murty, DRCOG, FFPM
SCMO, Contraceptive and Sexual Health Services, Leeds, UK

BOOK REVIEWS


This highly readable book tells the story of the X chromosome from Aristotle’s musings on gender differences right through to a modern understanding of the genetics of the X chromosome. The author’s engaging style makes modern genetics accessible both to the complete layperson and to those of us for whom preclinical genetics are a hazy memory. Bainbridge is a lecturer on comparative anatomy and physiology at the Royal Veterinary College in London and uses his broad knowledge of the animal world to set human sex determination in a fascinating wider context. Would who have thought that many species could do away with the Y chromosome? The author asks even more of us in the way things are said in this book, I do think it seems an unachievable goal. We know that doctors need to have sufficient priority to merit a share of the consultation. Having felt cause to argue in particular with the way things are said in this book, I do think it has some use in presenting pharmaceutical information about sexual function. Perhaps that is after all what it intended to do.

Reviewed by Alex Connan, MRCGP, MIPM
General Practitioner and Family Planning Doctor, Edinburgh, UK

The book is divided into two halves. The first deals with the effects of drugs on the causation of sexual problems and the second addresses drug treatment for sexual problems. The introduction to the treatment of premature ejaculation says: ‘None of the mentioned agents has been approved by the FDA for the treatment of PE’. It seems unusual to devote a whole chapter on treatment to unlicensed drugs.

Although passing reference is made to the ‘psychosocial context’ it would be easy reading this book to feel that the answers to sexual problems lie only in pharmacology. The authors state that: ‘Many men have … unrealistic expectations of their sexual performance’. There was no suggestion that this too needs addressing. The authors ask even more of us in the consultation. They state: ‘It is critical to obtain a baseline measure of sexual function prior to starting a new pharmacological treatment’. This seems an achievable goal. We know that doctors are not yet very good at talking with their patients about sex. Furthermore, the time constraints within which we all work mean that this issue will not always have sufficient priority to merit a share of the consultation.

REVIEWED

Reviewed by Kate Weaver, MB ChB, FFPM
Staff Grade Doctor in Reproductive Health Care, Edinburgh


This American book has a catchy title that completely describes what you are getting – and does it! It seems obvious to point out that the book is very pharmacological, but perhaps the subject cannot be fitted quite so completely into pharmacological categories. These ‘facts’ seem to have been over-interpreted when presented to ‘practising physicians’. The lists of references included a wide range of animal studies (mice, cats, rats, hamsters, stallions, male mosquito fish and striped bass). I was concerned as to how much of this could really be evidence of sexual function in the human species.

The book introduces many pharmacological studies, the pros and cons of different formulations and the wide variety of information available on different drugs, to offer a feedback page and the site is peer-reviewed,
Breast cancer and abortion: collaborative reanalysis of data from 53 epidemiological studies, including 83 000 women with breast cancer from 16 countries

Louise Melvin

*J Fam Plann Reprod Health Care* 2004 30: 278-279
doi: 10.1783/0000000042177306

Updated information and services can be found at:
http://jfprhc.bmj.com/content/30/4/278.3.citation

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