Letters to the Editor

Practice-based commissioning

Richard Ma raises some very interesting points in his commentary... Fam Plann Reprod Health Care 2006; 32(1)52

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we need to maintain the pressure on PCTs to give practice and PCTs will be crucial in ensuring that reducing health inequalities. As PBC is and well-being of their populations, and sexual service can flourish.

White Paper will create an environment in which outside hospitals. We can only hope that the will continue to employ clinical staff and any Government has now clarified the situation: PCTs provide any services at all. This created major commissioning were first announced, the services will no longer have the support they is unable to meet current needs, will be further reduced. And professionals providing Level 1 and 2 services will no longer have the support they need to be able to provide family planning care to specialist family planning nurses. Above all, many women will no longer have access to a full range of contraceptive methods because their general practice does not provide them. When the Government’s proposals for changing the emphasis of primary care trusts (PCTs) away from providing services to commissioning were first announced, the indication was that PCTs would no longer provide services at all. This created major concerns for sexual health services because of the lack of alternative providers (other than for some specialty services in some parts of the country) and fears about fragmentation of services. The Government has now clarified the situation: PCTs will continue to employ clinical staff and any advice about developments in local services will be made locally by the PCT. Such decisions will be taken in the light of the White Paper on health outside hospitals. We can only hope that the White Paper will create an environment in which the networks and collaboration between different components of a comprehensive sexual health service can flourish.

PCTs have a vital role in ensuring the health and well-being of their populations, and sexual health services are vital in improving health and reducing health inequalities. As PBC is implemented, the partnership between general practice and PCTs will be crucial. Some of the uncertainties that need to be addressed include the adequacy of resources are allocated to improving and developing sexual health services. Above all, we need to maintain the pressure on PCTs to give sexual health the priority it deserves.

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References

Emergency contraception and liver enzyme-inducing drugs

The CEU Guidance on drug interactions with hormonal contraception includes discussion on progestogen-only emergency contraception in women using liver enzyme-inducing drugs. In Table 2 of page 145 I read: “Take a total dose of 2.25 mg levonorgestrel in single dose as soon as possible and within 72 hours of unprotected sex”. The authors stated on page 146: “The most recent

BNF, however, supports taking 2.25 mg LNG as a single dose at first presentation. The CEU was unable to identify any new data to support a single dose of 2.25 mg LNG.”

The British National Formulary (BNF), Volumes 49 and 50 of March 2005 and September 2005 reported, under interactions on pages 407 and 412, respectively, the following:

For emergency contraception in patients on liver enzyme-inducing drugs, 1.5 mg levonorgestrel is taken immediately and 750 µg taken 12 hours later.

A previous CEU Guidance on emergency contraception in women taking liver enzyme-inducing drugs made the same recommendations as BNF Volumes 49 and 50. BNF states in the preface on page iii that the current edition must always be used when making clinical decisions.

Please clarify this discrepancy.

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References

Reply

Thank you for the opportunity to respond to the letter from Dr Nader Al-Hassan, highlighting apparent inconsistencies within our CEU Guidance on drug interactions with hormonal contraception. I share Dr Al-Hassan’s frustrations about conflicting guidance from different sources. As Dr Al-Hassan says, in our 2003 CEU Guidance on emergency contraception we recommended a regimen of levonorgestrel 2.25 mg as a divided dose for women taking concurrent enzyme-inducing drugs; in our 2005 Guidance on drug interactions with hormonal contraception we recommended 2.25 mg as a single dose. There is no research evidence about the most appropriate emergency contraception regimen for women taking concurrent enzyme-inducers and our guideline in the drug interactions Guidance was, in fact, based on the advice in the volume of the BNF that was current at the time of writing. In our Guidance we refer to Volume 49 of the BNF (September 2004). Publication of that volume contains the advice on interactions with hormonal emergency contraception: “the dose of levonorgestrel should be increased to 2.25 mg taken as a single dose”. We note that in an earlier volume (Volume 43) and in a later volume (Volume 49) the BNF does recommend a divided dose in this circumstance. We do not know the reason why the BNF has altered its advice from a divided dose to a single dose, and back again, in successive volumes. However, on the basis of available data, we doubt that the difference in regimen makes any difference to efficacy.

The CEU is currently updating our Guidance on emergency contraception for publication in the April 2006 issue of this Journal. We will again be reviewing available evidence in developing an updated recommendation on concurrent emergency contraception and enzyme-inducers.

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NICE Guidance on LARC

I welcome the useful advice in the National Institute for Health and Clinical Excellence (NICE) long-acting reversible contraception (LARC) Guidance that was published so that it states that all progestogen-only methods may be used by women who have migraine with or without aura. However, although this broad recommendation is applied to injectable contraceptives and subdermal implants, it is unclear for the levonorgestrel intrauterine system (LNG-IUS).

The Guidance notes an increase in headache incidence with IUS use and that “In the current WHO-MEC recommendation, the LNG-IUS is assigned to (WHO) category ‘2’ for initiation and category ‘3’ for continuation in women who have migraine with focal symptoms at any age”. Although the subsequent recommendation by NICE is that “progestogen-only methods, including MEC, may be used by women who have migraine with or without aura”, it is unclear to me if NICE is suggesting that the WHO-MEC guidance does or does not apply.

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References
5 Cardiovascular disease and oral and injectable progestogen-only contraceptives and combined contraceptive pills. Results of an international, multicenter, case-control study. World Health Organization Collaborative Study of Cardiovascular Disease and Steroid Hormone Contraception. Contraception 1998; 57:315-324.

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NICE Guidance on LARC

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