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 and pleased to see that it states that all progestogen-only methods may be used by women who have migraine with or without aura. However, although the 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 recommended category 2 for initiation and category 3 for continuation in women who have migraine with focal symptoms at any age”. Within the subsequent recommendation by NICE is that “progestogen-only methods, including the IUS, 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.

In summary, I understand that the current concern of increased headache reported in LNG-IUS users. However, there are no data to support that its use is associated with increased aura. Although it is recognised that women who have migraine, particularly with aura, and take combined oral contraceptive pills are at increased risk of ischaemic stroke, it is not clear that the case for progestogen-only contraception. Hence, progestogen-only contraception can be used by women with any type of migraine, irrespective of whether aura is present before, or develops after, commencing the method. Clearly, it may be worth considering stopping the method to assess whether or not symptoms improve, but this should be on clinical grounds, not on safety. Hence I recommend that both NICE and WHO consider modifying the current International Headache Society (IHS) criteria to be WHO Category 2 for both initiation and continuation of all progestogen-only methods.

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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 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, that “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 preamble on page iii that the current edition must always be used when making clinical decisions.

Please clarify this discrepancy.

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Reply
Thank you for the opportunity to respond to the letter from Dr Nader Al-Hassan regarding apparent inconsistencies within our CEU Guidance on drug interactions with hormonal contraception. 1 I share many of 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 that the most appropriate emergency contraception regimen for women taking concurrent enzyme-inducers and oral contraceptive agents is the same 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 88 of the BNF (September 2005). The 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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LETTERS
Letters to the Editor
Practice-based commissioning
Richard Ma raises some very interesting points in his commentary on ‘Practice-based commissioning’ and its impact on sexual health services in this issue of the Journal.1 In my view, he is right to encourage sexual health providers to start thinking now about the opportunities that the new arrangements may provide for developing a more integrated service that encompasses contraception, abortion and STI provision in a community setting. A major barrier to doing so is the 1967 Abortion Act, which states that abortions can only take place in NHS hospitals and GP surgeries. However, a creative collaboration with a local acute trust may overcome this difficulty, as is already the case in some areas.

While PBC does present opportunities for new partnerships and improved patient pathways, there are also risks associated with it. For example, while many PBC practices do not need the help of dedicated contraception services, and with the increased influence that general practice will have over the contracts of services, there may be a major loss of expertise, which will have far reaching consequences for contraceptive services not only now but in the future. This is particularly true of the three-level model for sexual health services that is the basis of the National Strategy for Sexual Health and HIV. The already greatly stretched training capacity, which 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 from more specialist training services. 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 services) and the removal of many parts of sexual health and sexual health services. However, a creative collaboration with a local acute trust may mean that community contraceptive clinics are no longer commissioned to provide services.

Where this happens, as is highly likely in some areas, it will be crucial that a key person in each PCT who is aware of the need for dedicated contraception services, and with the increased influence that general practice will have over the contracts of services, there may be a major loss of expertise, which will have far reaching consequences for contraceptive services not only now but in the future. This is particularly true of the three-level model for sexual health services that is the basis of the National Strategy for Sexual Health and HIV. The already greatly stretched training capacity, which 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 from more specialist training services. Above all, many women will no longer have access to a full range of contraceptive methods because their general practice does not provide them.

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NICE Guidance on LARC

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