Editor’s Note: Missed pill correspondence

Interested readers may wish to note that there has been a letter1 from the Clinical Effectiveness Unit (CEU) published in the Lancet, in response to the April Editorial2 by Diana Mansour and Ian Fraser.

The main points of this letter can be summarised as follows: The authors believe that most women know the name and type of their pill and would be able to apply the recommendations. They believe having different rules for 20 and 30 µg ethinylestradiol pills minimises intervention and inconvenience for the maximum number of women. They state a pill has been missed only when 24 hours have elapsed after the scheduled time. They did not review any evidence cited by Missed contraceptive pill recommendations. Lancet 2005; 366: 1264.

A comment in response to the letter has been placed on the Lancet’s website.3 For our readers’ convenience, we have permission to reprint it in full below.

Comment on Lancet website: Missed pill guidelines

Dear Sir

In the same week that the Faculty of Family Planning’s Clinical Effectiveness Unit (CEU) stated that “we assume that most women know the name and type of their pill”,1 a paper in the Journal of Family Planning and Reproductive Health Care suggested that 41% of a group of educated women were not even sure whether they were taking a high- or low-dose pill.2 In the same issue of that Journal, Thetford, Primary Care Trust explained that they felt they could not use the new guidelines in their area because their clients “would have difficulty following the new advice”.3

There have been letters to the Journal pointing out the deficiencies of the CEU’s guidelines on missed pills, over the last 6 months, yet the widespread concerns are simply being ignored by the Faculty. Is it a valid excuse to say that papers that suggest their guidelines are unsafe can be ignored? Why did the CEU not take those findings into account when considering important new guidelines?

Competing Interests: None.

References

Barbara Hollingworth, DRCCG, FFPP
Consultant and Lead Clinician in Family Planning and Reproductive Health, Redbridge and Havering PCTs, Essex, UK

Caroline Marfleet, MB BS, FFPP
Consultant in Family Planning and Reproductive Health, Colchester General Hospital, Turner Road, Colchester CO4 5LT, UK

Elphis Christopher, MMPP, FFPP
Consultant in Family Planning and Reproductive Health, Haringey PCT, London, UK

Ruth M Clancy, MMPP, FFPP
Consultant in Family Planning, Sutton and Merton PCT, Surrey, UK

Gillian Robinson, FRCCG, FFPP
Associate Specialist in Sexual and Reproductive Health, Southwark PCT, London, UK

Interested readers should refer to the Lancet’s website for any further responses or comments.

References

LETTERS

DPMA and BMD

Following the Committee on Safety of Medicines (CSM) advice,2 women who are members of depot medroxyprogesterone acetate (DPMA) in November 2004, has there been continued discussion regarding its effects on bone mineral density (BMD). The BMD may well be a long-term factor for bone health and fracture risk.

To examine women’s views and knowledge regarding this issue, a short anonymous questionnaire for women using DPMA who attend contraception was produced. It was given to all women prior to their consultation appointment at three clinics between January and June 2005. All 64 patients to whom the questionnaire was given completed it, and their ages ranged from 17 to 46 (mean, 25.8) years. They had been using DPMA for a mean of 40 months and 9 years (mean duration of use, 2.6 years).

Of these patients, 53 (83%) were aware of the possible effects of DPMA on BMD, and all of these women felt that their concerns had been discussed. Four of these patients (all in their twenties) were considering a change of contraception following reading about the CSM advice in the media or as a result of discussing this issue with a health care professional. One woman was definitely going to change her method of contraception to a progestogen-only implant.

Those women who were not considering a change to their contraception (i.e., 90.5% of those aware of the link with reduced BMD) cited various reasons for continuing DPMA including:

- the potential reversibility of BMD changes
- researching the topic themselves and finding the evidence weak
- belief that they were not at risk of osteoporosis
- worrying about forgetting pills
- concern related to side effects with other forms of contraception.

There were 11 patients who stated that they were not aware of any effects DPMA may have on bone health. Of these, 9 (81.8%) felt they had been given a Family Planning Association leaflet before or at the start of DPMA use, which highlights the importance of ensuring patient understanding within the consultation rather than relying on written information which may not be read, understood or retained. All the women in this group had the effects of DPMA on BMD discussed with them after completion of the questionnaire and all decided to continue using this method of contraception.

As health professionals, it is easy to presume that women attending for repeat prescriptions are well informed if it is based on current evidence, even if this involves sharing uncertainty regarding guidelines.

From this small audit only one woman planned to change her contraceptive method from DPMA, although four others were considering a change (8% of the total). We do not know, however, how many women have chosen to start other birth control methods in the light of this information or those who have discontinued DPMA and are now using less effective methods. Overall DPMA still remains a popular choice for women wanting a highly effective yet reversible method of contraception, and the majority of established users surveyed wish to continue its use.

Ruth Parry, MB BS, MFRCGP
VTS Registrar, Grangemere Clinic, Newcastle Upon-Tyne, UK

Diana Mansour, FRCCG, FFPP
Consultant in Community Gynaecology and Reproductive Health Care, Grangemere Clinic, Newcastle Contraception and Sexual Health Service, Newcastle General Hospital, Westgate Road, Newcastle-upon-Tyne NE4 6BE, UK.
E-mail: diana.mansour@newcastle-pct.nhs.uk

Audit of documentation of female sterilisation

We read with great interest the paper by Anderson et al.1 on documentation of preoperative counselling for female sterilisation: a complete audit cycle in which the authors have provided evidence on the usefulness of a standardised proforma in the documentation of counselling women requesting sterilisation. Their documentation was fully compliant with the Royal College of Obstetricians and Gynaecologists (RCOG)’s guidelines2 only when a standardised proforma was used during the counselling.

A recently completed re-audit of documentation of female sterilisation carried out in our department has identified areas where there is room for further improvement in our practice. It is our experience that the awareness of the standards set out in the RCOG’s guidelines was not enough on its own to facilitate changes towards improving the quality of communication and to ensure that our documentation process was fully compliant with the RCOG’s guidelines.

Sterilisation is a major cause of litigation involving gynaecological procedures, accounting for 25% of all claims notified to the Medical Defence Union.3 In order to minimise the risk of litigation, the need for adequate documentation and the use of a checklist as an important part of informed consent procedures was identified in a previous study.4

The present authors have now demonstrated that the introduction of a standardised proforma can significantly improve the level of compliance with the RCOG’s guidelines by improving the quality of documentation.1

If our ultimate goal is to improve the quality of care and thereby reduce the high level of complaints and litigation associated with female sterilisation, then the available evidence would suggest that units providing the female sterilisation service should seriously consider the use of a standardised proforma that would ensure that a consistent and adequate information as recommended by the RCOG is provided to all patients requesting sterilisation.

Deeba Yunes, MB BS
Senior House Officer, Edith Watson Unit, Burnley General Hospital, Casterton Avenue, Burnley BB10 2QG, UK

Competing Interests: None.

References
LETTERS/ERRATA

PK Sarkar, M Obstet Gynae, FRCOG
Consultant Gynaecologist, Edith Watson Unit,
Burnley General Hospital, Casterton Avenue,
Burnley BB10 2PQ, UK

References
1 Anderson J, Gunn E, Hunter M, Owen P. Documentation of

Effective copper surface area of IUDs

Many providers of intrauterine devices (IUDs) wrongly believe that the nominal surface area of copper IUDs equals the effective copper surface area. The reality is different, however. This letter explains the situation.

Studies suggest that a good contraceptive efficacy is obtained with IUDs having a copper surface area of 200 mm². Failure rates of the T-Safe® TCu200 are of the order of 3.0 at 2 years. When the copper surface area is increased to 380 mm², failure rates are usually less than 1.5 years. No additional reduction in failure rate is seen when the copper surface area is increased further.

These clinical studies were conducted with copper IUDs provided with a copper wire wound around the stem of the IUD. It is important to distinguish between IUDs with copper wire and the ones that have copper sleeves or a combination of the two. The remark by Kosonen is important. “Only in the case of sleeves is the combination of the two. The reality is different, however. This letter explains the situation.


Inappropriate advertising?

I was shocked to see the Emotional Bliss advertisement in the last issue of the Journal (J Fam Plann Reprod Health Care 2005; 31: 301). I do not feel that such advertisements conform to the ethical medical standards of a scientific journal. I fully understand that commercials are essential to finance the publication of a journal but advertisements of sex toys are totally out of character of a scientific journal.

N S Qureshi, MRCOG, DFFP
Specialist Registrar, Wrexham Maelor Hospital,
Wrexham, UK. E-mail: nq@doctors.net.uk

Reply

I was sorry to hear that Dr Qureshi objected to this advertisement. Many of the readers of this Journal are necessarily involved in psychosexual therapy as part of their professional activities. In 2004, the Journal published a special supplement about parenthood, emotional well-being and sexuality in which an advertisement for the firm Emotional Bliss appeared and was welcomed by the readership. Our readers are mainly concerned with contraception and reproductive health and, because of this, they treat women more than men. The commonest sexual problem in women is loss of sexual desire, and many therapists find that they are a useful adjunct to treatment for sexual responsiveness in many women.

The Journal’s Editorial Board believes that enabling doctors and therapists to recommend a safe and discrete source for sexual aids assists the women that they are treating.

Anne Szarewski, PhD, FFPP
Editor-in-Chief, Journal of Family Planning and Reproductive Health Care (on behalf of the Editorial Board)

ERRATA

Chlamydia screening in general practice: views of professionals on the key elements of a successful programme,

The Journal wishes to apologise for any inconvenience or embarrassment caused to Dr Aileen Clarke that might have resulted from her name appearing in print as Aileen Clark within this article and on the contents page of the journal issue.

Community-based distribution and contraception usage in Iran. Jahanfar S, Ghodsi M, Shahpoorian F, Jamshidi R,
J Fam Plann Reprod Health Care 2005; 31(3): 194–197

Unfortunately the details printed in the article for one of the contributing authors, Dr Zahra Ghodsy, were incorrect.

The correct information is as follows: Dr Zahra Ghodsy, Azad University of Toyskeran, Hamedan, Iran. The Journal wishes to apologise unreservedly to Dr Ghodsy for any inconvenience or embarrassment this inadvertent error might have caused.

References
Audit of documentation of female sterilisation

Deeba Yunus and P K Sarkar

*J Fam Plann Reprod Health Care* 2006 32: 53-54
doi: 10.1783/147118906775275208

Updated information and services can be found at:
http://jfprhc.bmj.com/content/32/1/53.4.citation

**Email alerting service**

*These include:*

Receive free email alerts when new articles cite this article. Sign up in the box at the top right corner of the online article.

Notes

To request permissions go to:
http://group.bmj.com/group/rights-licensing/permissions

To order reprints go to:
http://journals.bmj.com/cgi/reprintform

To subscribe to BMJ go to:
http://group.bmj.com/subscribe/