Oral contraceptives and diabetes mellitus: an update

There has long been interest in the possible relationship between oral contraceptive (OC) use and diabetes mellitus. In 1991, we reported our findings (in this Journal) on 45 women who had been referred to hospital for diabetes during follow-up in the Oxford-Family Planning Association (Oxford-FPA) contraceptive study. No association was found with OC use.1 We nonetheless thought it would be of interest to comment briefly on the findings for this disease up to the time that individual follow-up of the study participants ceased in July 1994 (follow-up of cancer registrations and death notifications is still continuing).

The Oxford-FPA study methods have been described in detail elsewhere.2 In brief, the study included 17 032 white women who, when recruited between 1960 and 1974, were married and aged between 25 and 39 years. At entry, 56% were using OCs, 25% a diaphragm and 19% an intrauterine device. These women (save for certain subgroups – see Vessey and Painter3) were followed up annually and information was collected about changes in contraceptive methods, pregnancies and their outcome, hospital visits and deaths. Women who at entry to the study reported that they were suffering from diabetes were excluded from the present analysis. Women who were 85 years of age were excluded. Only the first hospital referral (inpatient or outpatient) was taken into account in the analysis.

As expected, hospital referral was strongly positively related to age and body mass index (BMI). In addition, referral was three times as common in women of lower social class (I–IV) as in women of upper social class (I–II), a difference only partly explained by BMI. Analyses of hospital referral rates in relation to OC use were therefore adjusted for age, BMI and social class.

Our first analysis compared women ever using OCs with those never doing so. The rate ratio was 0.8 with a 95% confidence interval (CI) ranging from 0.5 to 1.3. Rate ratios for hospital referral and total duration of OC use were as follows (95% CIs are given in parentheses): never used, 1.0 (reference category); 0.9 (0.3–2.1); 0.7 (0.3–1.7); 0.9 (0.5–1.7); 145 months or more, 0.6 (0.2–1.6). Corresponding rate ratios in relation to interval since last use of OCs were as follows: never used, 1.0 (reference category); current–48 months, 0.7 (0.3–1.4); 49–96 months, 0.7 (0.3–1.7); 97–144 months, 0.6 (0.2–1.5); 145 months or more, 1.5 (0.7–2.8). The data were too few to enable analyses to be done by type of OC, but it should be noted that preparations containing 50 μg oestradiol made up 67% of OC exposure. OCs containing a greater amount of oestrogen made up 67% of OC exposure. OCs containing 50 μg oestradiol made up 67% of OC exposure. OCs containing 50 μg oestradiol made up 67% of OC exposure.

In conclusion, the final results of the Oxford-FPA study with respect to diabetes mellitus have been grouped by Martin Vessey FRCP FRBS Emeritus Professor of Public Health, Unit of Health Care Epidemiology, University of Oxford Old Road Campus, Headington, Oxford OX3 7LF, UK. E-mail: martin.vessey@dhpc.ox.ac.uk.

Acknowledgement

The authors are grateful to the Medical Research Council for financial support throughout the course of the Oxford-FPA study.

References


Increase in IU D expulsions

We write to raise awareness of an apparent increase in intrauterine device (IUD) expulsions noted since we started using the TT380 Slimline® in Autumn 2005.

As clinic policy we changed our first-choice copper IUD to TT380 Slimline, mainly because of its 10-year licence compared with the T-Safe® Cu380A. In early 2006 we noticed that a number of women were returning soon after insertion with either full or partial expulsion.

Two experienced doctors fit the majority of IUDs, either personally or as part of supervision for the FFPRHC Letter of Competence in Intrauterine Techniques (LoC IUT). We reviewed their IUD data from 1 January 2005 to 1 March 2006, choosing the dates to give roughly equivalent numbers of T-Safe Cu380A and TT380 Slimline insertions. We excluded insertions done by any other clinicians.

From the beginning we were able to identify those women who had not returned for follow-up and those who did not continue with the IUD. Only women who were inserting in the first 3 months after insertion were included, although later expulsions also appear to be increased. We also noted an increase in women asking to have their IUD removed within the first 3 months. The results are shown in Table 1.

Table 1 Summary of IUD fitting data

<table>
<thead>
<tr>
<th>Device</th>
<th>Total</th>
<th>No data</th>
<th>No follow</th>
<th>Expelled</th>
</tr>
</thead>
<tbody>
<tr>
<td>T-Safe Cu380A</td>
<td>115</td>
<td>3</td>
<td>24</td>
<td>0</td>
</tr>
<tr>
<td>TT380 Slimline*</td>
<td>108</td>
<td>9</td>
<td>17</td>
<td>4 (4)</td>
</tr>
<tr>
<td>Nexa-T 380</td>
<td>15</td>
<td>1</td>
<td>2</td>
<td>0</td>
</tr>
<tr>
<td>GyneFix® (IUS)</td>
<td>3</td>
<td>0</td>
<td>1</td>
<td>0 (1)</td>
</tr>
<tr>
<td>Mirena® (IUS)</td>
<td>196</td>
<td>2</td>
<td>39</td>
<td>2 (1)</td>
</tr>
</tbody>
</table>

IUS, intrauterine system.

Of the seven women who expelled the TT380 Slimline, four also expelled a replacement device. Similarly, of the two women who expelled the T-Safe Cu380A, one was known to have a fibroid uterus and also expelled her replacement device. None of the expelled devices had been fitted as part of LoC IUT training.

Although this is only a small observational study, we are concerned that this may be early evidence of a problem with the design of the TT380 Slimline. Given that the frame of this device seems to be softer and less springy than the T-Safe Cu380A and the discontinued, but similar, Ortho Gynae T380®, the TT380 Slimline takes longer to open fully post-fitting in vitro. We are careful to fit the device immediately after loading so the device is compressed within the tube for as little time as possible.

We value feedback from colleagues on their experience of using the TT380 Slimline.

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Liquid-based cytology

We very much welcome Dr Williams’s commentary1 in the July 2006 issue of the Journal on any advantages that liquid-based cytology (LBC) may offer and his critical review of the systematic review by Davey et al.2 It is surprising that the favourable results of the large five pilots in England, Scotland, Wales and Northern Ireland were not included. Two recent publications from this country echo the LBC pilots as regards significant reductions in inadequate rates with LBC.3,4

Our positive experience at PathLinks with LBC is in line with these publications. PathLinks is a pathology unit which serves Greater Lincolnshire and Goole; the catchment population is approximately one million. The laboratory processes around 65 000 cervical cytology samples annually. The liquid-based service implementation of LBC began in June 2005, with one of the six PCTs converting every 6 weeks coinciding with training completion of a pathologist, a checker and three cytoscreeners. A total of 30 staff converted and provided the present service. Turnaround time for LBC was 6 weeks. Presently this is 2 weeks, with around 90% of results being reported within a week. The inadequate rates were as follows: preconversion (April 2004–March 2005) 7.7%, during conversion (April 2005–March 2006) 4.9% and post-conversion 0.8%. The high-grade rates during these periods were 0.95% and 1.1%, respectively, suggesting concordance with the expectation of increased sensitivity of LBC. Our cytoscreeners have found the LBC slides to be ‘clean’ and easier to interpret compared to conventional smears. Detection of endometrial cells is more frequent although this often made the diagnostic challenge and cytoscreeners would be reluctant to return to interpreting conventional smears.

Whether the LBC can be made more cytoscreener-friendly is being explored by the NHS Health Technology Assessment Programme through the MAVRIC trial. Automated technology may make identification of abnormal cells easier. The computerised software will direct the cytoscreeners to probe some 20 locations on a slide rather than painstakingly searching the whole slide. Furthermore, one of the machines (FocalPoint™) can sort the abnormal slides into quintiles. Up to 25% of the samples are likely to be classified as ‘no further review’ meaning that manual reading is not required. The MAVRIC trial set up in August 2005 compares two automated cervical screening systems: Mulea manual screening. Cytology samples are randomly allocated to reading by manual screening alone or by one of the two automated technologies, then compared up by manual screening. The trial is expected to end in 2009 and the published results are due in 2011. Further uses of LBC are being actively researched. LBC lends itself to the hybrid capillary technique for the human papillomavirus test5 and for chlamydia screening.b

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LETTERS

Letters to the Editor