Oral contraceptives and cancer

Many of this Journal’s older readers will be familiar with the Oxford-Family Planning Association (Oxford-FPA) contraceptive study and will recall the massive contributions to data collection. Accordingly, I was delighted that the Journal Editor had chosen the most recent publication from the study1 as the cover for a Journal Review. I am also grateful to Dr Mills for taking so much trouble to produce a succinct summary of a complex paper.2 There are, however, one or two points about the review to which I would like to draw readers’ attention.

First, I would like to stress that the majority of the women in the study were followed up individually until mid-1994, although individual follow-up for a substantial subgroup of women ceased earlier than this. With regard to cancer registrations and death notifications, all women (save for those who emigrated) were followed up until the end of 2004 using information provided by the National Health Service Central Registries to supplement data collected during the course of individual follow-up.

Second, the Journal Review does not include any confidence intervals for the rate ratios (no doubt in the interests of saving space). This is, perhaps, of concern mainly for invasive cervical cancer, where the Oxford-FPA findings were considerably more unfavourable than has been described in most other studies. As the Oxford-FPA study included only 59 cases of this disease (as opposed to six cases in the reference group who never used oral contraceptives), confidence intervals around the rate ratios were wide.

Finally, while the population studied was certainly of higher social class than the general population, it was not “predominantly Social Class 1”. The paper only gives the proportion of women from Social Classes 1 and 2 combined and this figure was 41%.

These are relatively minor points that do not detract from the substance and conclusions of the careful review prepared by Dr Mills.

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References

Increase in IUD expulsions

Further to the letters of Drs Hawkins and Callander1 and my own,2 I received a telephone call from a doctor in Hong Kong expressing concern about where the Oxford-FPA findings were considerably more unfavourable than has been described in most other studies. As the Oxford-FPA study included only 59 cases of this disease (as opposed to six cases in the reference group who never used oral contraceptives), confidence intervals around the rate ratios were wide.

IUD expulsions

I would like to express my total agreement with Dr Yadava in his letter entitled ‘Increase in IUD expulsions’ published in the January 2007 issue of the Journal.2 It was some years ago that I noted the rod in the T-Safe 380A® intrauterine device was about 1 cm shorter than the introducer tube. Since this discovery, and the feeling that the device seemed to ‘cling’ to the tube while the latter was being readjusted, I have systematically shortened the tube before insertion in exactly the same way as Dr Yadava describes and have explained to others the reason why.

I cannot prove that the expulsion rate of these ‘adjusted’ fittings has fallen, but the fitting procedure is a more satisfying experience.

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Reference

Pressed for time: providing the Standard Days Method and oral contraceptives in India

Recently, we reported in this Journal1 that Rwandan providers exchanged on average 39 items of relevant information as they counselled clients who chose the Standard Days Method (SDM)2 and only 31 with those who chose pills. Similarly, 75% of SDM clients and only six pill items were addressed by at least 95% of providers in the consultations. We studied a list of 23 essential SDM items that can be prioritised in the service delivery protocol and training providers to focus counselling on essential topics. A satisfactory list of 23 essential SDM items can be established and emphasised in SDM training. If providers, instead of using a more personal selection of items from a method’s technology tables, or national reproductive health care guidelines a subset of essential items for standard use in interactions with clients.

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References
1 León FR, Blair C, Huapaya A, Lundgren R, Victoria Jennings, Ragini Sinha, Margaret Curtis, Ana Huapaya, Fredrick Ormanjhi, and Ormanjhi blocks of Ranchi. The SDM was introduced through a 2-day workshop for providers after a 2-day contraceptive update workshop that reinforced pill (and other methods) delivery.

The consultations lasted on average 9 minutes and 41 seconds with SDM clients and 8 minutes and 4 seconds with pill clients. The number of information items exchanged with SDM clients reached 23.20 on average and with pill clients 21.75. Only 16 specific items from the SDM checklist were addressed by at least 60% of providers. Essential contraindication questions (e.g. ‘Ask whether my period comes more or less when I expect them?’); ‘Ask about partner’s willingness to abstain or use protection on fertile days,’ (48%) and follow-up instructions (e.g. ‘Tell me to see the provider if period does not return the day the band passes over the last bead, 46%’; ‘See the provider if period returns before the day on which the band should reach the dark brown bead, 43%’) routinely failed to meet the 60% standard. Important gaps were found in pill counselling as well (e.g. ‘Ask about my blood pressure or measured it, or someone else did, 3%’; ‘Tell me to return to the clinic right away if I have severe headaches and/or blurry vision, 9%’; To return if I have any question or concern, 39%). Nonetheless, the study results suggest that SDM and pills might be successfully offered in less than 10 minutes if counselling were further streamlined and focused. This will require prioritising items in the service delivery protocol and training providers to focus counselling on essential topics. A satisfactory list of 23 essential SDM items can be established and emphasised in SDM training. If providers, instead of using a more personal selection of items from a method’s technology tables, or national reproductive health care guidelines a subset of essential items for standard use in interactions with clients.

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