
It is widely accepted that use of the combined oral contraceptive pill (COCP) reduces the risk of epithelial ovarian carcinoma. However, during the last 30 years there have been significant changes in the oestrogen and progestogen content of the COCP, with the aim of decreasing adverse effects. This population-based case-control study examined the effect of varying oestrogen and progestogen potencies on ovarian carcinoma risk.

The study identified 745 women who had a histological diagnosis of primary epithelial ovarian carcinoma. A total of 943 controls were randomly selected from an annual household survey data and a frequency-matching approach used to ensure comparability to cases. Each participant was interviewed to record sociodemographic information, menstrual, reproductive and gynaecological histories, and exogenous hormone use. Photograph albums were used to aid identification of COCP preparations. Women identified as having exclusively used the COCP were divided into six categories: (i) unknown formulation, (ii) high oestrogen and high progestogen, (iii) high oestrogen and low progestogen, (iv) low oestrogen and high progesterone, (v) low oestrogen and low progesterone and (vi) various potency OCP users. Oestrogen levels greater than 0.035 mg and less than 0.035 mg as low oestrogen and high progestogen, (iii) high oestrogen and low progestogen, (iv) low oestrogen and high progestogen, (v) low oestrogen and low progesterone and (vi) various potency OCP users. Oestrogen levels greater than 0.035 mg ethinylestradiol were defined as high oestrogen and less than 0.035 mg as low oestrogen potency. Progestogens were expressed in milligrams of norgestrel equivalent. Those less than 0.3 mg norgestrel were classified as low potency. Participants using parental, sequential or progestogen-only contraceptives were excluded. Odds ratios (ORs) were calculated for the association of these OCP categories with ovarian carcinoma risk. Adjustments were made for an extensive list of variables including age, ethnicity, family history of ovarian cancer, gravidity, age at menopause and duration of COCP use. Use of any COCP was associated with a 50% reduction in epithelial ovarian carcinoma risk. Reduced risk was observed in all categories of COCP by potency when compared with paired hormonal contraception, with ORs of 0.62, 0.55, 0.45, 0.19 and 0.26 for categories (ii) to (vi), respectively. Although the odds of ovarian cancer were lower using low potency COCPs than in users of high potency COCPs, this difference was not statistically significant.

The study then went on to analyse women exclusively using COCPs containing a single progestogen, norethindrone, with no inter-individual variation in dose. They found a significant decreased risk of developing ovarian carcinoma in users of low dose (0.5 mg or lower) norethindrone compared to women taking high-dose preparations.

The authors concluded that COCPs with low oestrogen and progestogen potency provided significant reduction in epithelial ovarian carcinoma risk. However, actual numbers of participants using low-dose preparations were small (3 cases and 12 controls). The authors suggest that the protective effect may be due to ovarian suppression, which occurs regardless of the potency of the COCP. They suggest the improved protection with low potency preparations may be due to increased compliance. Limitations of the study include small samples for high potency preparations may be due to increased compliance. Limitations of the study include reliance on patient recall for preparations of COCP. This resulted in 16 women being classified as ‘unknown OCP’ users, casting doubt on the reliability of recall in the other groups. In addition, oestrogenic and progestogenic components of the COCP have unique pharmacological features and are not completely comparable. Nonetheless, this study does suggest that low potency COCPs are of equal efficacy as high potency preparations at reducing epithelial ovarian carcinoma. Future studies with larger sample groups are needed to confirm the association and aid risk–benefit analysis for individual women.

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READERS’ CONTRIBUTIONS INVITED ON ‘A BETTER WAY OF WORKING’

Continuing in this issue (see article on page 193) is the feature entitled ‘A Better Way of Working’, the purpose of which is to disseminate service delivery suggestions likely to be of interest and relevance to the Journal’s readership.

Readers are invited to submit suggestions based on their own personal experience for consideration by the Journal Editor. Contributions should not exceed 250–500 words and should be written in a standardised format responding to the following four questions (or similar): Why was change needed? How did you go about implementing change? What advice would you give to others who might be considering a similar course of action? How did you show that the change had occurred?

All contributions should be submitted via the Journal’s online submission system at http://jfprhc.allentrack.net.
Contraception for the older woman: an update

Gilly Andrews

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