Implanon® use in overweight clients

In reference to the letters from Drs Barber and Waters1 and Dr Matiluko 2 about the earlier replacement of Implanon in heavier women, the FPRHCC Guidance is that weight does not have an effect on the efficacy of Implanon.2 It would be a shame if women over 70 kg were subject to an unnecessary change of weight does not have an effect on the efficacy of Implanon.2

Dr Matiluko in his reply2 suggests that women resuming bleeding after a period of amenorrhea on Implanon should seek advice about earlier replacement. The CEU recommends using a UKMEC Selected Practice Recommendations for Contraceptive Use, namely that women developing bleeding should be investigated if clinically indicated and that the summary of product characteristics of Implanon remain sufficient to inhibit ovulation throughout the 3 years and a return to bleeding does not demonstrate a return to fertility.5

Reference to the letters from Drs Barber and Waters1 and Dr Matiluko 2 about the use of Implanon in women >70 kg where we agree early replacement may be unnecessary both for the patient and in terms of expenditure.

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Reply

I am writing in response to the letter1 written by Dr Cogswell and colleagues. I would suggest they read my letter2 in the January 2008 issue of the Journal carefully. It was not a generic comment about irregular bleeding on Implanon but rather advice based on the case reported (i.e. the resumption of regular periods in HIV-seropositive patients on antiretrovirals using Implanon for long-term contraception) which should prompt a review with a view to alternative contraceptive cover.

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References

3 Faculty of Family Planning and Reproductive Health Care Clinical Effectiveness Unit. Members Enquiry Response Enquiry Reference [1072].
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Risk assessment documentation in COC prescribing

Documentation is important in the ever-expanding defensive medicine culture, particularly when prescribing medication. As a female Foundation 2 Doctor in General Practice, I see many women request contraceptive pill checks. I was surprised to find that very few consultations documented a risk assessment when the pill was first prescribed, considering factors that are very clearly outlined in the British National Formulary (BNF). In response to this observation I audited the initial consultations of combined oral contraceptive pill (COC) prescribing to review the documentation of a risk assessment in general practice. The audit served to quantify the standard of medical record keeping and set as a marker of the risk involved in not prescribing the COC. All audits have been taken to improve record keeping in this area, and in turn improve clinical care. Consequently I feel that an interesting and relevant topic for discussion.

Recording a full risk assessment prior to prescribing the COC is difficult within the time constraints of general practice. However, before prescribing a hormonal method of contraception it is the clinician’s responsibility to determine and record any contraindications to use in the indi.

Clear guidelines exist for prescribing the COC in the BNF3 and World Health Organization Medication Eligibility Criteria (WHOMEC)4 and in particular, recognise a risk among women with a personal or family history (FH) of venous thromboembolism (VTE).5

An audit carried out in a surgery in North Devon showed 60% of the COCs prescribed during the first issue of the COC demonstrated poor performance in this area. Of the 134 women audited, only 4% of consultations documented specifically ‘no FH of VTE’ and 14% included a broad statement like ‘no contraindications’. The remaining 82% of consultations made no mention of a risk assessment. A negative personal history of FH was recorded in 1% of consultations and a further 21% made a general comment with reference to past medical history. The BNF parameters of height, weight, body mass index, smoking status and blood pressure were only completed in 24% of consultations and only 3% included all of these five parameters and had a broad statement regarding ‘no contraindications’. No consultations included a specific statement about VTE risk, personal or within the family, and all of these parameters.

With the increasing emphasis on defensive medicine, documentation needs to be improved to protect the practitioner and demonstrate the patient gave fully informed consent. In cases where clear guidelines exist on prescribing, general practitioners should ensure their computer templates offer relevant prompts for questioning to allow rapid, complete documentation of the consultation. Ultimately it is the responsibility of the prescriber to ensure that risks do not outweigh the benefits and, if in doubt, consider alternatives.

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Author’s note

The text of this letter is taken from a poster presentation by the author at the Medical Woman’s Federation’s ‘90 Years and Beyond’ Conference on 1 November 2007 at the Royal College of Obstetricians and Gynaecologists, London, UK.

References

Risk assessment documentation in COC prescribing

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