women tended to be more educated and 70% had a high school diploma. The women were recruited from four different geographical regions and included large Hispanic and black populations. Some selection bias is also likely because women were not selected to receive medical treatment (women with a strong preference for surgical treatment would not have agreed to be randomised). Urban populations in the UK are far more diverse and the educational level varies significantly depending upon the area a particular hospital serves. This could have a greater impact on the women’s understanding of treatment choices and subsequent side effects likely to occur, thus affecting QOL.

Conclusions

This study aims to inform us about the focus of counselling prior to patients undergoing the procedure and helps women to better understand the differences in experiences, expected adverse effects, and efficacy between the two methods as well as the similarities in recovery and QOL measures. It is unlikely to change the actual points we use when counselling women about different treatment options for EPF, but gives the clinician more confidence in assuring women about changes in QOL following their treatment choice.

Reviewed by Neelima Deshpande, MRCoG, DFSRH
Staff Grade Doctor in Sexual and Reproductive Healthcare, Heart of Birmingham Teaching PCT, Birmingham, UK


Saffron is the world’s most expensive spice, which has been traditionally advocated for stomach, digestive problems and mood disorders. Iran produces 81% of the world’s supply so it is not surprising that the first trial of saffron in premenstrual syndrome should come from the University of Tehran, Iran. This group have previously published on the use of saffron in depression.

The paper reports a double-blind placebo controlled study to investigate whether saffron could relieve symptoms of premenstrual syndrome. I would suggest that it is probably a pilot study since only 50 women were recruited of whom 47 completed. This should not detract from the study, which appears to have been very well designed and performed.

The authors are to be congratulated in that they recruited 78 women of whom 50 enrolled for the study, which appears to have been very well designed. Urban populations in the UK are far more diverse and the educational level varies significantly depending upon the area a particular hospital serves. This could have a greater impact on the women’s understanding of treatment choices and subsequent side effects likely to occur, thus affecting QOL.

Relevance to current practice

Measurement of testosterone and free testosterone was developed mainly to investigate levels in men and identify high levels in women with conditions such as hirsutism. It is still unclear how identifying low levels in women can be used in sexual medicine, especially, as shown again in this article, correlation between testosterone levels and sexual satisfaction is poor or non-existent. A large number of articles have appeared discussing the reliability of measuring free testosterone levels, and although this trial used a sensitive method, doubts remain about the usefulness of such tests in clinical practice.1,2 The Endocrine Society guidelines stated: “We recommend against making a diagnosis of androgen excess in women based on the present because of the lack of a well-defined clinical syndrome and normative data on total or free testosterone levels across the lifespan that can be used to define the disorder.”

The lack of correlation between hormone levels and sexual satisfaction confirms other work suggesting that the situation is more complex than just a low testosterone level. The (cited) large Australian community-based, cross-sectional study of 1423 women aged 18–75 years, who were randomly recruited via the electoral roll in Victoria, Australia, from April 2002 to August 2003, showed no correlation.

It seems unlikely that most women would want to use a testosterone spray to their abdomen once a day to correct their (possibly) low testosterone levels in order to perhaps achieve less than one extra SSE a month.

Reviewed by Gilll Wakley, MD, FFRRH Advisor, Journal of Family Planning and Reproductive Health Care

References

IMPLANON® RECOMMENDATION FOR INSERTION SITE

Organon, a part of the Schering-Plough Corporation, wish to advise healthcare professionals responsible for inserting Implanon® that the recommended insertion site has recently changed and it is advised that implants are now inserted 8–10 cm above the medial epicondyle of the humerus. Enclosed with this issue of the Journal is a leaflet that describes the recommended insertion site and also includes a number of Q&As about Implanon insertion.

A revised Summary of Product Characteristics (SmPC) for Implanon has also been published. The instructions contained in the revised SmPC should be followed for all future insertions and removals of Implanon. The SmPC can be found at www.emc.medicines.org.uk.

For more information about Implanon, or to obtain further copies of the leaflet, interested individuals should contact Schering-Plough Medical Information Department. Tel. +44 (0) 1707 363636/363425.
Safety and efficacy of a testosterone metered-dose transdermal spray for treating decreased sexual satisfaction in premenopausal women: a randomized trial
Gill Wakley

*J Fam Plann Reprod Health Care* 2008 34: 272
doi: 10.1783/147118908786000442

Updated information and services can be found at:
http://jfrhc.bmj.com/content/34/4/272.2.citation

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