Sisters doing it for themselves

I was interested to read the commentary by Anne Szarewski describing how to individually tailor a woman’s combined oral contraceptive (COC) regimen to minimise the amount of breakthrough bleeding she has to experience each year.1 However, in view of the article on repeat abortion (Das et al.) in the same issue of the journal, we should not be more concerned in preventing pregnancy in COC users.2 Das et al. state that 35% of first attenders were using COC and 55% at repeat abortion.

It is not uncommon to see patients who have become pregnant on the COC pill despite taking it regularly. One such patient, whose case report we would like to highlight, highlights the need for a further licence to enable a change to a 24/4 formulation for the cheaper generic COCs that would make drug companies reluctant. We can never be certain which patient fell pregnant despite full compliance with the COC taking ‘rules’ – what is certain is that there will be some women whom this affects each year, and they are likely to be young, sexually active women. This seems very unfair on them when in this day and age we have other contraceptive options available.

Emily Gwinnell, MBBS, MRCP
Clinical Assistant, Contraceptive and Reproductive Healthcare, Ashwood Centre, St Marys Hospital, Kettering, UK
E-mail: emilygwinnell@doctors.org.uk

References

Sisters doing it for themselves

One of the main reasons for women to choose their combined oral contraceptive (COC) use is to reduce their frequency of menstrual bleeds; however, as their responsible elder siblings we have a duty to control their contraceptive regimen, if necessary, to slow down their chance of becoming pregnant. Several alternative formulations such as 24/4 or continuous-use pill regimens are available in other countries including the USA and Australia, but aren’t currently available in the UK, although one has been granted a licence here with a launch date awaited. This will not come at a price. Surely all the COC manufacturers should provide a product that is more effective?

In particular ‘An IUS is effective as emergency contraception’ I would certainly have answered in the affirmative.

We all know that the intrauterine system (IUS) is not licensed as emergency contraception (EC) and never will be because of its cost, but if it were being planned as the ongoing method of contraception, it would certainly be effective as EC. Whether postcoital in the first 72 hours (IUD) not relying on its copper content for its efficacy. The copper inhibits sperm mobility and the ability to fertilise the ovum. When it is fitted after sex, it is relying on the woman’s ability to prevent implantation. Therefore any IUD would be effective, including the IUS. It therefore follows that it would be safe to fit the IUS on any day up to the estimated time of possible implantation – Day 19 in a 28-day cycle. It would not of course be the ideal time in the cycle, but might well prevent an unplanned pregnancy in a patient where you are not certain that she will return at a more ideal time.

Beth Devonald, MBBS, MRCGP
Consultant in Sexual and Reproductive Health, Lincoln County Hospital, Lincoln, UK
E-mail: devonald@btinternet.com

References
2 Reply
I agree entirely with Dr Robinson1 that long-term health effects of longer-cycle combined oral contraceptive (COC) use have not been formally studied for more than a few years and we should ensure that monitoring continues. However, we should remember that monthly bleeding is in fact not the norm for healthy, reproductive age women. As Thomas et al. have pointed out: “in hunter-gatherer times, women had infrequent menstruation: when they had closely spaced pregnancies, they breastfed their infants for long intervals (which suppresses ovulation and menstruation), and they died before reaching menopause.” Prehistoric women had as few as 50 menstruations per lifetime, whereas the modern woman has approximately 450 bleeding episodes.2 In addition, the bleeding that occurs during the pill-free interval is simply due to hormonal withdrawal, not to any physiological need. The studies of longer cycle/continuous pill-taking regimens have in fact not given any indication that the adverse event or metabolic profile of extended-regimen oral contraceptives differs in any clinically significant manner from traditional 28-day regimens, while having many health benefits.3 Indeed, even a Cochrane Collaboration review in 2005 concluded that “continuous dosing of COCs is a reasonable approach for women without contraindications to COCs.”4

Anne Szarewski, PhD, FFPRH
Clinical Consultant and Honorary Senior Lecturer, Cancer Research UK Centre for Epidemiology, Mathematics and Statistics, Wolfson Institute of Preventive Medicine, London, UK
E-mail: a.szarewski@qmul.ac.uk

References

Genuine Depo-Provera® failure

After reading the case report of Lucinda Farmer and Elizabeth Patel entitled ‘Contraceptive failure of Depo-Provera®: long-acting reversible contraceptive (LARC) methods do fail too’ in the January 2009 issue of this Journal1 we would like to report a case of genuine Depo-Provera failure. Recently, a 15-year-old girl presented to our family planning clinic with abdominal pain, breast tenderness, nausea, vomiting and tiredness and off on for 1 week. The patient was fit and healthy, with a body mass index (BMI) of 19, who was very happy with this method. She started Depo-Provera® from age 15 to 21 years and had been planning to be given in accordance with the licensed use of any day up to the estimated time of possible implantation – Day 19 in a 28-day cycle. It would not of course be the ideal time in the cycle, but might well prevent an unplanned pregnancy in a patient where you are not certain that she will return at a more ideal time.

Beth Devonald, MBBS, MRCGP
Consultant in Sexual and Reproductive Health, Lincoln County Hospital, Lincoln, UK
E-mail: devonald@btinternet.com

References
2 Reply
The Clinical Effectiveness Unit (CEU) would like to refute the suggestion in Dr Devonald’s letter1 that the 2nd generation of progestogen-releasing intrauterine system (LNG-IUS, Mirena®) can be used for emergency contraception (EC). There is no evidence that the LNG-IUS is effective as EC and it is not licensed for such use.
IUS as emergency contraception

Beth Devonald

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