OCs and VTE: a practical answer to an old question

In a recent commentary in this journal, Jürgen Dinger1 argued that “the risk of VTE [venous thromboembolism] attributable to COCs [combined oral contraceptives] is a class effect, primarily dependent on the dose of estrogen” and that the type of progestogen used in the COC probably does not influence this risk. In an editorial that accompanied the publication of the two largest studies to date on this topic, Nick Dunn2 concluded: “All of the more recent progestogens, possibly except norgestimate, make us seem to be at a disadvantage with regard to VTE”.

As VTE is a very rare event, it is unreasonable to expect the answer to the progestogens and VTE question from a randomised controlled trial. We may thus never be able to exclude residual confounding as a possible explanation for the higher VTE rates found with newer progestogens.

Luckily in clinical practice this does not matter much. For COCs, as for any treatment, health professionals should always consider the safest and most effective treatment, and in the absence of knowing differences between treatments we should then consider costs.

Most patients requesting a COC request it solely for contraception. Most of these patients will be satisfied with a COC containing a second-generation progestogen, usually levonorgestrel (LNG). Dr Dinger does not question that COCs containing LNG are at least as safe and as effective as those containing one of the newer progestogens.

The basket of care offered by sexual health services is constantly changing. More than was the case in the past, we promote subdermal and intrauterine methods and offer sexually transmitted infection (STI) and HIV screening and manage genital tract infection. To afford to do this we have to keep costs as low as possible. Where budgets are finite and probably shrinking, the risk of prescribing COCs containing a newer progestogen instead of LNG can be measured in fewer implants or intrauterine methods inserted and fewer chlamydia or HIV tests undertaken.

This is as good a reason as any to adhere to Faculty Guidance on ‘First Prescription of Combined Oral Contraception’, which states: ‘A monophasic COC containing 30 μg ethinyl estradiol with norethisterone or levonorgestrel is a suitable first pill (Grade C)’.

Rudiger Pittrof, MD, MRCOG
Consultant, Enfield Community Services, Reproductive and Sexual Health (RASH), London, UK
E-mail: rudiger.pittrof@enfield.nhs.uk

Ulrike Sauer, MD
Specialist Registrar, Enfield Community Services, Reproductive and Sexual Health (RASH), London, UK

References
3 Josip Culig, MD, PhD
Professor, Department of Pharmaceutical Epidemiology, Andrija Stampar Institute of Public Health, Zagreb, Croatia

Filschef clip migration and retention

We wish to advise journal readers about an unusual case of Filschef clip migration and retention inside the ureteral cavity that to our knowledge has never been reported before.

A 68-year-old woman, with three previous vaginal births, presented with postmenopausal bleeding for 2 weeks. She underwent a laparoscopic Filschef clip sterilisation 25 years ago and had been menopausal for 16 years. An ultrasound scan suggested an endometrial polyp that was confirmed on hysteroscopy. A closed Filschef clip was seen within the ureteral cavity and attached to the polyp by flimsy adhesions. The clip was removed along its longitudinal axis with forceps after dilatation of the ureteric ostium. The ureteric ostium was not evident except for a small dimple at its expected site. Histology confirmed a benign endometrial polyp.

The clip was lying relatively freely inside the ureteral cavity without being expelled. The likely sequence of events could have been a low-grade foreign body inflammatory reaction that resulted in incorporation and subsequent burrowing of the clip through the ureteral wall into its cavity. Burrowing and migration through the Fallopian tube is also a possibility and could explain the closure of the right ostium by post-inflammatory adhesions.

Laparoscopic sterilisation with Filschef clip remains a popular method of permanent contraception since its introduction by Marcus Filschef in 1951. It is a simple method, with a failure rate of 1 in 200.1 The 12.7 mm long and 4 mm wide titanium clip is lined with silicone rubber and is closed round the Fallopian tube by means of an applicator leading to avascular tubal necrosis. The tube eventually divides and the stumps heal leaving two occluded ends.2 The clip usually remains attached to the site of tubal section and becomes detached if a delay in peritonealisation, the clip may become detached and migrate through tissue planes. This is estimated to occur in 0.6 per 1000 cases.3 Detached clips are most commonly found within the peritoneal cavity, typically in the pouch of Douglas or the paracolic gutters. Migration to the urinary bladder, vagina, rectum and into the perineum leading to an ischiorectal abscess has
Drospirenone and VTE

Marcel Leppeé, Mirela Eric and Josip Culig

*J Fam Plann Reprod Health Care* 2010 36: 44
doi: 10.1783/147118910790291127

Updated information and services can be found at: http://jfprhc.bmj.com/content/36/1/44.3.citation

These include:

**Email alerting service**

Receive free email alerts when new articles cite this article. Sign up in the box at the top right corner of the online article.

Notes

To request permissions go to: http://group.bmj.com/group/rights-licensing/permissions

To order reprints go to: http://journals.bmj.com/cgi/reprintform

To subscribe to BMJ go to: http://group.bmj.com/subscribe/