LETTERS TO THE EDITOR

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 classical 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 in the British Medical Journal 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, now 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 prioritize the safest and most effective treatment, and in the absence of knowledge 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 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 subermal and intruterine methods and offer sexually transmitted infection (STI) and HIV screening and manage genit tract infection. To afford to do this we have to keep costs as low as possible. Where budgets are finite and probably shrinking, the cost of prescribing COCs containing a newer progestogen instead of LNG is measured in fewer implants or intrauterine methods inserted and fewer chlamydial 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)”.

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References

Drospirenone and VTE

Following publication in the October 2009 issue of the commentary article regarding the risk of venous thromboembolism (VTE) with combined oral contraceptives (COCs) and subsequent criticisms,1,2 we would like to share some information regarding prescribing in Zagreb, Croatia of a recently introduced COC, containing 3 mg drospirenone and 30 µg ethinyl estradiol (DRSP/EE) (Yasmin®). We collected data in the city of Zagreb during the period 2004–2008, employing various data sources as follows: data on inpatients from Zagreb; data on the causes of mortality; data on side effects from the Agency for Drugs and Medicinal Products; and data on drug use from Zagreb pharmacies. The total female population under surveillance was approximately 250 000.

In Zagreb, use of COCs in general increased by 31% between 2004 and 2008. This rising tendency was especially pronounced after 2005, when the combination DRSP/EE was introduced. In 2005, DRSP/EE was accounted for 15.4% of the overall utilisation of COCs, which increased to 57.7% in 2008, yielding a 4.4-fold increase. Other COCs classified as fixed combinations of progestogens and estrogens showed a decrease in this period. In common with other COCs, in Zagreb DRSP/EE is issued on private prescription by pharmacies. COCs are usually prescribed by gynecologists, but may also be prescribed by other specialists.

The number of reported side effects of all drugs of any kind increased by 69.2% (i.e. from 993 in 2005 to 1680 in 2008). Annual trends in the rate of hospitalisation for VTE were followed in all age groups as well as in those potentially exposed to COCs. Data on the significant increase in the use of DRSP/EE and concurrently very low rates of hospitalisation for VTE, which constitute a death rate, decline, suggest that there is no correlation between these two parameters.

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Reference

Filshie clip migration and retention

We wish to advise journal readers about an unusual case of Filshie clip migration and retention inside the ureteric 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 Filshie 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 Filshie clip was seen within the ureteric cavity and attached to the polyp by flimsy adhesions. The clip was removed along its longitudinal axis with forceps after dilating the ostium. The right 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 ureteric 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 ureteric 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 Filshie clip remains a popular method of permanent contraception since its introduction by Marcus Filshie in 1981. It is a safe procedure, 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 separation and becomes detached in a delay in peritonisation, 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 paraocular cavities. Migration to the urinary bladder, vagina, rectum and into the peritoneum leading to an iatrogenic abscess has

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Another example is Clamelle® (azithromycin), now the first oral antibiotic in the UK to be available without a prescription to asymptomatic individuals with a positive chlamydia test and their partners.

This year the Committee of Advertising Practice (CAP), which is concerned with regulating advertising in the UK, carried out a review of its code that involved a public consultation. The outcome of the CAP code review could facilitate the promotion of sexual health services in future. Some people do not support the advertisement of sexual health services, and there is a small chance the outcome may be different from that anticipated. However, in this regard, one study on direct to consumer advertising (DTCA) of medicinal products showed:

- It increases consumer awareness
- It motivates consumers to seek additional information from health professionals and other sources
- It aids patient-doctor discussions
- It even motivates the pursuance of lifestyle changes in place of POMs.

In addition, a systematic review of the impact of DTCA on the consumer’s perspective5 concluded that:

- DTCA can facilitate the compliance process with older consumers (in this case, it will be compliance with a contraceptive method)
- It appears to increase the demand for treatments and medicines (hopefully long-acting reversible contraception, in this case).

This evidence, and the increasing raising awareness through advertising has the potential to be successful and could help combat the country’s teenage pregnancy and sexually transmitted infection rates.

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References
2 The Medicines Act 1968. Accessible at The UK Statute Law Database, Office of Public Health Sector Information, Part of the National Archives, www.statuteslaw.gov.uk [Accessed 13 May 2009]. Part VI, Sections 95 (a), (b) and Part VIII, Section 130 have been reformed.

What’s in a name?

In the January 2004 issue of this journal, Toni Belfield criticised the continuing use of the term ‘coil’ for intrauterine devices (IUDs). Six years later, as one of the largest distributors of intrauterine contraception in the UK, I share her consternation!

Toni made the point that much of our language has changed over time (e.g. ‘automobile’ to ‘car’) and therefore the change from ‘coil’ to ‘IUD’ should not be difficult. Unfortunately, I feel she missed one crucial point and that is that we are all intrinsically, linguistically lazy. In fact, all the examples Toni gave of changing terminology proved this, in that all the newer terms had fewer syllables than those they were replacing (e.g. ‘long-playing record’ to ‘CD’ or ‘album’). In contrast ‘coil’ has only one syllable, but ‘IUD’ has three and that, I believe, is why the majority of us still use ‘coil’ in preference.

‘Coil’ is a hard, cold, slightly sinister term, reminiscent of reptilian features. My suggested alternative, on the other hand, is monosyllabic, soft, warm, and friendly and may even endow the humble IUD with a flirtatious overtone. I think it should call IUDs ‘Tees’ (or ‘Tease’?). The intrauterine system (IUS), of course, would be ‘Hormonal Tease’. (Come to think of it, I went out of those when I was 20."

After a few years of colloquial use, I anticipate male pulses racing when they hear the phrase ‘Tee’s ready” but perhaps experiencing slight anxiety at the cautionary “Hurry up, Tee’s getting cold”. ‘Tee dances’ would take on a whole new face, of life not to mention ‘Tee parties’ and ‘Tee for two”.

So that is my New Year Resolution – I shall not use the term ‘coil’ ever again. It’s ‘Tee’ for me, and I hope all readers of this journal will follow suit. Anyone, anyone for Tee?"

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