


6. Cameron S, Glasier A, Fine P, Mathé H, Gainer E. When given at mid-cycle (when risk of pregnancy by ulipristal acetate (UPA) is more effective than levonorgestrel (LNG)). There is clear evidence that ulipristal acetate (UPA) is more effective than levonorgestrel for emergency contraception within five days of unprotected intercourse: a randomised controlled trial. Abstract presented at the 8th Congress of the European Society of Gynaecology, Rome, Italy, 10–13 September 2003.


Letter to the editor

In response to the letter1 from Drs Pittrof, Rubenstein and Sauer we would like to make the following points:

1. There is clear evidence that ulipristal acetate (UPA) is more effective than levonorgestrel (LNG). Biomedical studies have shown that when given at mid-cycle (when risk of pregnancy by UPA is pre-ovulatory) UPA is able to delay ovulation whereas LNG is no better than placebo.1–3 Studies have also demonstrated that UPA has endometrial effects (which may or may not contribute to its efficacy) whereas LNG does not.4–5 The recent randomised controlled trial and meta-analysis of studies comparing UPA with LNG for emergency contraception (EC) that we published in the Lancet showed that UPA reduces the risk of pregnancy by almost one half compared to LNG.6

2. A Cochrane review actually concluded that mifepristone with etonorgestrel (>25 mg) were significantly more effective than LNG for preventing pregnancy when used for EC.7

3. As regards the possible effect of UPA if taken in pregnancy, we observed in our study that there were pregnancies in women treated with UPA that were judged to have occurred well before treatment, that continued after UPA treatment.6 Furthermore, the miscarriages in women who received UPA was similar to that in women who had LNG and no different from that observed in the general population of pregnant women.6 Whilst there have been a small number of normal births in women who received UPA, clearly UPA is a new drug and so it is only appropriate that a European pregnancy registry has been established to collect more information on effect on ongoing pregnancy.

4. We discussed the possible interaction of a progestrone receptor modulator (PRM) with hormonal contraception.8 We commented in this Journal9 and concluded that further research is required, because the requirement to abstain or use barrier methods for the remainder of the menstrual cycle is not clear.5

5. Drs Pittrof, Rubenstein and Sauer express concern that women who cannot access National Health Service abortion services may try to procure abortion from UPA. We commented in our commentary this Journal9 and concluded that further research is required, because the requirement to abstain or use barrier methods for the remainder of the menstrual cycle is not clear.5

6. Cameron S, Glasier A, Fine P, Mathé H, Gainer E. Pregnancy outcomes following points:

a) The 'bridging' contraception. However, in spite of this, challenges are believed that contraceptive service providers should present evidence for themselves, and welcome UPA as an advance in EC that is more likely to help women avoid an unintended pregnancy than LNG. Sharon Cameron, MRCOG, MFSRR Consultant Gynaecologist, Well Woman Services, Dean Terrace Centre, Edinburg, UK. E-mail: sharon.t.cameron@nhslothian.scot.nhs.uk

Anna Glasier, FRCOG, FFRRH Consultant, Well Woman Services, Dean Terrace Centre, Edinburgh, UK

References


Combined pill and GTD

I have read the new UK Medical Eligibility Criteria for Contraceptive Use (UKMEC) guidelines1 and am surprised and concerned that the recommendations regarding hormonal contraception, particularly the combined oral contraceptive pill (COC) and gestational trophoblastic disease (GTD), have been changed. It was used to be recommended that the COC was not taken until the beta-human chorionic gonadotropin (ß-hCG) levels had fallen to normal following evacuation of a hydatid mole.2 The new (2009) guidelines state the COC can be started whilst the ß-hCG levels are decreasing, persistently elevated and in the presence of malignant disease. The accompanying notes suggest that starting the COC in this situation may decrease the requirement for chemotherapy (by promoting a more rapid reduction in ß-hCG levels). This advice differs to that given by the Royal College of Obstetricians and Gynaecologists (RCOG), the Patient UK website (a common source of information for both general practitioners and patients) and the Charing Cross Hospital gestational trophoblastic neoplasia (GTN) website, which recommend that hormonal methods [and intrauterine devices (IUDs)] are not used until the ß-hCG level has returned to normal.3 I am puzzled by the new advice given by UKMEC. The references given in the 2009 guidelines all predate, and are very similar to, those in the 2006 guidelines. Why has the advice changed? I am aware of the paper on Contraception3 suggesting that both the COC and IUDs can be used in women with GTN. This paper also quotes some publications suggesting that COC use reduces the risk of women developing post molar trophoblastic disease; however it is not quoted by UKMEC 2009.

Professionals and patients become confused when contradictory advice is given. As a specialist we should be more aware of this than most following the problems that have arisen after various ‘pill scares’. I would be interested to hear why UKMEC have changed their guidance but

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