Welcome to the latest issue of Women’s Health Research Review.

This issue focuses primarily on contraception, with comments provided by Dr Christine Roke from Family Planning. Highlights include a study of an extended 24-day regimen of a drospirenone-containing COC, a review of the long term efficacy of IUDs, and an assessment of the prevalence of uterine perforation associated with their use. We also include an interesting survey of faecal and urinary incontinence after childbirth, and a NZ study outlining the difficulties some young Māori women have finding a lead maternity carer.

We hope you find our selection interesting and look forward to receiving any feedback you may have.

Kind regards,
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Cardiovascular and general safety of a 24-day regimen of drospirenone-containing combined oral contraceptives

Authors: Dinger J et al.

Summary: The International Active Surveillance Study of Women Taking Oral Contraceptives investigated the risks associated with an extended 24-day regimen of drospirenone and ethinylestradiol (DRSP24d) compared to established COCs in a routine clinical setting. 85,109 women were included and followed up for 2–6 years. Three main cohorts were compared: new users of DRSP24d, users of 21-day regimens of DRSP-containing COCs (DRSP21d), and users of COCs without DRSP (non-DRSP), DRSP24d, DRSP21d, non-DRSP and levonorgestrel-containing COCs (LNG) showed similar incidence rates of venous and arterial thromboembolism, fatal outcomes, cancer, severe depression and other serious adverse events. Venous thromboembolism (VTE) incidence rates for DRSP24d, DRSP21d, non-DRSP and LNG were 7.2, 9.4, 9.6 and 9.8 VTE/10,000 woman-years, respectively. The adjusted VTE hazard ratio for DRSP24d versus non-DRSP was 0.8 (95% CI 0.5–1.3).

Comment: This large prospective cohort study of drospirenone-containing COCs vs non-drospirenone COCs and levonorgestrel COCs over several years and with a very low lost to follow-up rate found no significant difference in VTE rates between the groups. This is somewhat surprising given the results of other studies but this well conducted study is believed to provide better results than the database studies. It reports that the risk of VTE was highest within the first 6 months of COC use, reminding us to check on VTE risks such as a close family history of VTE or obesity before initiating a COC. In New Zealand, we are still likely to be starting most women on a subsidised second generation COC because of the cost.

Reference: Contraception 2014;89(4):253-63

Abstract
Extended use of the intrauterine device: a literature review and recommendations for clinical practice

Authors: Wu J & Pickle S

Summary: This literature review examined the prevalence of pregnancy outcomes associated with extended use of IUDs (including copper IUDs and the levonorgestrel intrauterine system [LNG-IUS]). There is good evidence to support extended use of the following devices among parous women aged ≥25 years old at the time of IUD insertion: the TCu380A and the Tcu220 for 12 years, the Multiload Cu-375 for 10 years, the frameless GyneFix® (330 mm³) for 9 years, the LNG-IUS 52mg (Mirena®) for 7 years and the Multiload Cu-250 for 4 years. Women aged ≥35 years at the time of insertion of a TCu380A IUD can continue use until menopause with a negligible risk of pregnancy. There were no data to support use of the LNG-IUS 13.5mg (Skyla®) beyond 3 years.

Comment: This review highlights the evidence that for women who have had a child and had their IUD inserted when they were at least 25 years old, their IUD remains effective beyond the licensed lifespan. We can recommend they leave their IUD in longer provided we make it clear that this is non-registered use. New Zealand’s new standard copper TT380 IUD is equivalent to a TCu380A. However the Mini TT380 has not been followed up for long enough to recommend use beyond the licensed 5 years.

Reference: Contraception 2014;89(6):495-503

Abstract

Intrauterine devices and the risk of uterine perforations: final results from the EURAS–IUD study

Authors: Heinemann K et al.

Summary: This multinational cohort study determined uterine perforation rates in new users of IUDs. The cohort comprised 61,380 women in 6 European countries (Germany, Austria, UK, Finland, Poland, and Sweden). 70% of the women were new users of a levonorgestrel IUD and 30% were new users of a copper IUD. Interim results showed 1.1 uterine perforations per 1000 insertions of levonorgestrel IUDs and 0.9 uterine perforations per 1000 insertions of copper IUDs. 71% of women with perforations had potential risk factors for perforation. Breastfeeding at time of insertion was associated with a 6-fold increase in perforation risk, regardless of the type of IUD. None of the perforations led to serious illness or injury.

Comment: A reminder of the increased risk of perforation when inserting an IUD into a breastfeeding woman. Surprisingly the insertion can seem quite straightforward and the woman may have no symptoms at the time or afterwards. So it is recommended that a woman return after about 6 weeks or after her next period so that the absence of visible strings can alert one to check for perforation or expulsion.

Reference: Obstet Gynecol 2014;123 Suppl 1:3S

Abstract

Women’s Health Research Review

Independent commentary provided by
Dr Christine Roke MB ChB, Dip O&G

Guest reviewer Christine is the National Medical Advisor for Family Planning New Zealand. She is vocationally registered in both Family Planning and Reproductive Health and Sexual Health scopes of practice. She practises from the Newmarket Family Planning clinic and combines her clinical work with teaching and professional development.
Contraceptive use among women presenting to pharmacies for emergency contraception: an opportunity for intervention

Authors: Michie L et al.

Summary: This study examined contraceptive use among women presenting to a pharmacy for emergency contraception (EC). Of the 232 women who requested EC from pharmacies in Edinburgh, they were asked to complete an anonymous questionnaire of contraceptive use; 211 of the women complied (91% response rate). 79% of the respondents were not using a hormonal method of contraception at the time of EC, but almost half (44%) wanted to. 64% of women agreed that it would be helpful if a pharmacist could supply a progestogen-only pill (POP). 110 clinicians working in sexual and reproductive health also completed a questionnaire (73% response rate). 92% of them were positive about a pharmacist supplying a POP at the time of EC.

Comment: While we all agree that ideally women should start effective contraception when they present for EC, the time required to assess whether they are suitable for a combined contraceptive pill and to teach them how to take it are barriers to offering it. This article suggests bridging with a POP which has few contraindications and is simple to take. We could apply the same principle when a woman is still in need of contraception presents for IUD or implant removal.

Reference: J Fam Plann Reprod Health Care 2014;40:190-195

Abstract

HSV-2 incidence by sex over four age periods to age 38 in a birth cohort

Authors: Dickson N et al.

Summary: This study examined the incidence of herpes simplex virus type 2 (HSV-2) over four age-periods to age 38 in a birth cohort. Participants in the Dunedin Multidisciplinary Health and Development Study were invited to provide serum for HSV-2 serology, and information on sexual behaviour, at ages 21, 26, 32 and 38. HSV-2 incidence rates were compared for the four age periods. By the age of 38, 17.3% of men and 26.8% of women had ever been seropositive for HSV-2. The incidence peaked for women from 21 to 26 years (19.1/1000 person-years) and for men from 26 to 32 years (14.1/1000 person-years). It then fell markedly for both sexes from age 32. The overall incidence rate ratio 1.9 (95% CI 1.4–2.7).

Comment: These data from the Dunedin longitudinal study show local HSV-2 prevalence. They indicate that a quarter of women contract HSV-2 compared to about a fifth of men and that infectivity declines with time. Useful data when we are talking to people presenting with genital herpes although we have to remember that HSV-1 infection is also common in genital sites – approximately half in some age groups.

Reference: Sex Transm Infect 2014;90:243-245

Abstract

Too old to have children? Lessons from natural fertility populations

Authors: Eijkmans M et al.

Summary: This study constructed an age curve to determine the age above which women in natural fertility populations become biologically too old to have children. The investigators reviewed 6 high-quality historical data sets (n=58,051) of natural fertility populations in which the distributions of female age at last birth were analysed. The populations represented different historical time periods, but the distribution of the ages at last birth was remarkably similar. The resulting cumulative curve for end of fertility showed that <3% of women had their last birth at age 20 years, 4.5% at 25 years, 7% at 30 years, 12% at 35 years and 20% at 38 years. Thereafter, the proportion increased to approximately 50% at age 41, almost 90% at age 45 and almost 100% at age 50.

Comment: I found this a fascinating article looking at the age of last birth in communities where fertility control is not practised. There was little variance in the 6 populations with the last birth about age 40 or 41. This confirms our ideas of when fertility drops dramatically. However it doesn’t change our advice to use contraception until menopause is confirmed by absence of menstruation for 2 years before 50 and 1 year after 50.

Reference: Hum Reprod 2014;29(6):1304-1312

Abstract

Combination contraceptives: effects on weight

Authors: Gallo M et al.

Summary: This review evaluated the potential association between combination contraceptives and changes in weight. A search of CENTRAL (The Cochrane Library), MEDLINE, POPLINE, EMBASE, and LILACS for studies of COCs, as well as ClinicalTrials.gov and International Clinical Trials Registry Platform (ICTRP) found 49 trials that met inclusion criteria. The four trials with a placebo or no intervention group found no evidence of a causal association between COCs or a combination skin patch and weight change. Most comparisons of different combination contraceptives showed no substantial difference in weight.

Comment: It can be quite difficult to counteract the myth of weight gain caused by taking “the pill” as young women are often at a stage of life when weight gain is common and is unacceptable in our society. David Grimes has put forward the view that it is unethical to tell people about possible side effects that are not evidence based. So Family Planning’s pamphlets now say that there is no evidence that oral contraception causes weight gain.

Reference: Cochrane Database of Systematic Reviews 2014;1:CD003987

Abstract
Consultation about urinary and faecal incontinence in the year after childbirth

Authors: Brown S et al.

Summary: This study determined the prevalence of postpartum urinary and faecal incontinence. 1507 nulliparous women living in Melbourne were recruited in early pregnancy, with follow-up at 3, 6, 9 and 12 months postpartum. In the first 12 months postpartum, 47% of women reported urinary incontinence and 17% reported faecal incontinence. 86% of the women visited a primary health-care practitioner at least once to discuss their health in the first year after childbirth, but only about 25% of them were asked about urinary incontinence, and <20% were asked about faecal incontinence. Discussion of symptoms with health professionals was most likely to occur in the first 3 months postpartum. More than 70% of women who reported severe urinary incontinence and/or faecal incontinence had not discussed it with a health professional.

Comment: This study clearly demonstrates that only a minority of people will bring up embarrassing issues such as urinary and faecal incontinence unless asked, even if they have moderate or severe symptoms. Most women were not asked about these symptoms postpartum, even in consultations relating to their own health. So it is up to us to take the lead.

Reference: BJOG 2014; published online Jul 9

Decision-making concerning unwanted pregnancy in general practice

Authors: Goenee M et al.

Summary: This study from The Netherlands examined whether the counselling provided by GPs to women with an unwanted pregnancy changed the women's minds about pregnancy termination. Data on unwanted pregnancy consultations were collected via the registration system of the NIVEL Primary Care Database Sentinel Practices from 2004–2010. Most women who consulted their GPs for an unwanted pregnancy opted for a termination and did not change their minds. Approximately one in six of the women were undecided. Of those who had made up their minds, 8% altered their decision after talking to their GP. Women with a higher gestational age and those who discussed alternatives with their GP were more likely to change their minds after talking to their GP. Women referred to an abortion clinic were less likely to change their minds.

Comment: Although The Netherlands has a different abortion process from New Zealand in that a 5-day reflection time is required, this review is of interest. Four out of five women with an unwanted pregnancy had made a decision about what they wanted to do before consulting their GP and four out of five of this group of women were wanting an abortion. Few women changed their mind. This supports the view that most women are able to make their own decision about an unwanted pregnancy and interaction with the medical profession is unlikely to alter that decision.

Reference: Family Practice 2014;31(5):564-570

Initiation of maternity care for young Māori women under 20 years of age

Authors: Makowharemahihi C et al.

Summary: This study examined access to maternity care for pregnant Māori women aged <20 years. 44 pregnant or recently pregnant Māori women <20 years of age completed a series of interviews during different stages of pregnancy and motherhood. Interview transcripts were analysed to identify emergent themes. Participants were found to have engaged early with health care services to confirm their pregnancy and to initiate maternity care. Barriers to access occurred at the first contact with a lack of information. Many participants felt inadequately supported to enable them to identify, confirm, and enrol with a midwife or hospital care. Those who received proactive support at the first contact had an appropriate maternity care pathway.

Comment: Many health professionals find it difficult enough to find out about the quality of care of a particular lead maternity carer (LMC) so it is no wonder that vulnerable women struggle to find a suitable LMC. And then the popular ones may be booked up. In this study, one young mum-to-be eventually walked into a maternity ward to see if she could connect up with a midwife! If you don’t know enough about your local LMCs to make a recommendation, you can offer the Ministry of Health’s 0800 MUM 2 BE phoneline.