ESC

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SUMMER SPECIAL

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Intro

Dear colleague,

In this special summer edition of the newsletter, we cover the current practices in Europe, ranging from emergency contraception to prevention of STIs. We are able to include these reports as they were the topics of discussion during the meet the expert sessions at the 9th ESC Congress Istanbul, Turkey, May 2006. I hope you will enjoy reading this newsletter.

Olga Loeber, ESC Secretary General

Emergency contraception

Group leaders : A. Webb (UK), G. Bartfai (Hungary)

14 participants from 9 countries including clinicians, researchers, NGO employees and the pharmaceutical industry.

Methods of EC currently available in each country and most accessible licence

	Levonorgestrel 1.5 mg	Levonorgestrel two 0.75 mg	IUD
Bulgaria	Pharmacy	On prescription	
Hungary	On prescription	On prescription	Restricted
Ireland		Available	Available
Italy		On prescription	Available
Lithuania	On prescription but can be bought	On prescription but can be bought	Available
Sweden	On general sale	On general sale	Available
Switzerland	On prescription	Pharmacy	Available
The Netherlands	On general sale	On general sale	Available
UK	Pharmacy	Pharmacy	Available

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The cost of the same product varies significantly between countries. From 5 to 38 EUR from a pharmacy and from free to 20 EUR from a doctor.

We discussed a 15 year old who needs EC and does not wish to involve her parents. In Hungary the visit is free, she can be seen alone but will have to pay for the prescription. Some clinics occasionally issue it free but they are open at restricted times. In Sweden she can get it free from a youth clinic or the hospital which is always open. In Switzerland she will have to attend hospital and will have to pay. In Ireland there are two youth clinics in the country. At a GP she will have to pay and not all GPs are willing to prescribe to young people alone. In Italy she should be able to access EC in theory but it depends where she is. If she attends a FP clinic the visit is free but not the treatment. In Lithuania and Bulgaria it is accessible through pharmacies but she will have to pay. In the Netherlands most contraception, including EC, is covered by insurance for women <21.

All got the new Clinical Guidance from the Clinical Effectiveness Unit of the FFPRHC (www.ffprhc.org.uk) and client leaflets on missed pills and EC published by the fpa (www.fpa.org.uk). We all agreed that hormonal EC is safe, has no medical contraindications and should be widely available. The EC IUD should be discussed and be made more widely available due to much higher effectiveness and offering ongoing contraception.

We all agreed on the clinical side but there are still large differences in availability and accessibility of EC related to models of delivery, funding of health services and politico-social attitudes. The discussion allowed us to consider what is and isn't effective in our countries and to think about ways of enhancing access to contraceptive services.

The report was written taking the comments of the participants at face value.

The value of non-oral methods

O. Loeber (The Netherlands) and B. Pinter (Slovenia)

Participants came from Latvia, UK, Italy, Brazil, Netherlands and Slovenia. The first question we discussed was which non-oral methods are available in each country.

Some methods were available in each country, like condom, natural methods, spermicides and copper IUD. Some methods were only available in some of the countries, like the patch, the ring, the hormonal IUD (IUS), injectable, implant and diaphragm. We concluded that all methods except COC and POP are non-oral methods.

Then we discussed what advantages they can have. The following was mentioned:

- Long lasting (IUD, IUS, injectable, implant)
- Cheap (natural methods)
- Double protection ((female) condom)
- In case of a medical problem: no first pass the liver effect, not influenced by gastro-intestinal problems e.g. irritable bowel syndrome, Crohn's, ...
- Some methods suitable for infrequent sexual contact (condom, diaphragm)
- Non contraceptive benefits (IUS, injectable)
- Dislike of hormones/ medicalization of contraception (condom, diaphragm, natural methods)
- Not having to take a pill everyday in case of forgetfulness, irregular life style (patch, ring, injectable, implant, IUD)
- Side effects/ contraindications of COC (non hormonal methods).

Then we discussed the disadvantages:

- Less reliable (natural methods)
- Costs can be high (implant, IUS)
- Side effects e.g. bleeding disturbances (implant, IUD, IUS)
- Coitus dependent methods (condom, diaphragm, withdrawal)
- Women may not like to put things in their vagina (ring, diaphragm)
- Women may not like to have something in their uterus (IUD)
- Myths about reliability and safety among women and doctors
- You need a doctor to get it out (implant, IUD)
- Dependent on partner (withdrawal, condom).

Our conclusions were:

1. the more methods available the better
2. the doctor should know all about them
3. the doctor should offer all appropriate methods
4. reliable information should be available to the general public
5. the choice should be based on women's needs and preferences
6. there should be no financial barriers
7. adapt the methods to preference, to side effects and to the needs of the individual woman, so there is a need for good counselling.

	Reliable	User dependent	Side effects	Cheap
IUD	yes	no	yes	depends
Implant	yes	no	yes	no
Injectable	yes	no	yes	yes
Patch	yes	a little	yes	no
Ring	yes	a little	yes	no
Condom	reasonably	yes	no	yes
Female condom	reasonably	yes	no	no
Diaphragm	reasonably	yes	no	yes
Sterilisation	yes	no	...	...
Natural methods	no	yes	no	yes
LAM	reasonably	yes	no	yes

Infertility and Contraception

H. Hassa (Turkey)

In the session related to infertility and contraception, Prof. Hassa's presentation covered two main topics.

I. Conditions that are known to be the causes of infertility the risks of which are reduced by contraceptive method use and II. Delay in the fertility due to contraceptive method use.

Topic I: Sexually transmitted infections (STI) affect fertility unfavorably in both sexes. The infertility rate following a single attack of acute salpingitis is 12-22%. The rate increases with more episodes. In men, gonorrhoeal and chlamydial infections may lead to urethritis and epididymitis. If appropriate treatment is not given, urethral stricture and infertility may ensue. Male Latex condoms are proven to protect against STI / HIV. Also other barrier contraceptives protect against pelvic infection.

Oral contraceptive (OC) use protects against pelvic inflammatory disease (PID), possibly by its effects on cervical mucus and reduction of menstrual blood flow and retrograde menstruation. The risk of being hospitalized PID is reduced by half in OC users. But OCs do not protect against HIV or lower genital tract STI (dual protection needed). Every year approximately 60 million unwanted pregnancies are terminated. 20 million of them are unsafe. Modern contraceptive use certainly will decrease unwanted pregnancies as well as mortality and morbidity including infertility problems related to unsafe abortions especially in developing countries.

Topic II: Large cohort and prospective studies related to fertility and OC use showed that ever use of OC is associated with a small, statistically nonsignificant increased risk of ovulatory causes of delayed fertility. 88% of cases reported an eventual pregnancy. There was no correlation between time to conception and parity or duration of contraceptive use. So absolute fertility was not impaired.

The median delay in return to fertility with hormonal injectables, depo medroxy progesterone acetate (DMPA) and norethisterone enanthate (NET-EN), is 10 and 6 months respectively from the date of the last injection, regardless of the duration of their use. With regard to implants (Norplant and Implanon), fertility returns rapidly following implant removal and pregnancy rates are 76-100% one year after removal.
Male and female surgical sterilization should be regarded as permanent methods. Pregnancy rate after laparoscopic microsurgical tubal anastomosis is 71% at 12 months. A complete fertility work out must be carried out and tubal reversal should be considered as an option for women <35 years old. Patients with poor prognosis should be referred straight to IVF-ET programs.

Contraception in HIV positive women

M. Lech (Poland), N. Ortayli (Turkey)

The session had 14 participants from different backgrounds and countries. There were international experts in the field such as Dr Tim Farley, STI/RTI team coordinator from the Reproductive Health and Research Department of World Health Organization and Elof Johansson, Vice President of The Population Council. There were also participants who were working as FP counselors and providers with HIV positive women from two different clinics in UK, two in Spain and one in South Africa. Therefore the session was very lively with the active participation and contributions of participants.

We presented a brief overview of WHO's guidance on FP in HIV (+) women and the interaction between contraception and HIV acquisition and disease progress, as well as possible interactions between antiretrovirals and contraceptives.

Dr Johansson summarized the microbicide study The Population Council was carrying out in South Africa. Several participants pointed to the need to overcome the fears of providers (especially the ones who are providing AIDS treatment) about negative effects of contraceptives on HIV/AIDS, though there is no evidence of any negative interaction. The group felt that there should be more activity to disseminate evidence-based guidance and overcome prejudices among providers and that the ESC should take a more active rol in that.

Premenstrual Syndrome (PMS)

A. Yildirim (Turkey), M. Van Santen (Germany)

Stieglitz and Kimble used the term "Premenstrual Intoxication" in 1949. Greene and Dalton used the term Premenstrual Syndrome (PMS) for the first time in 1953. In 1988 Magos described PMS as "Distressing physical, psychological, and behavioral symptoms not caused by organic disease which regularly recur during the same phase of the mensrual cycle, and which significantly regress or disappear during the remainder of the cycle."

According to the criteria used, 5–95% of women experience some recurrent PMS symptoms. 20-40% are mentally or physically incapacitated to some degree, and 5% experience severe distress. It occurs more commonly in the multiparous women, often after the first child. Among adolescent girls the incidence is 14-61%. Among adolescent girls with dysmenorrhea, 71% also have PMS.

Symptoms

More than 150 symptoms have been related to PMS.

Physical Symptoms	Psychological Symptoms
· Abdominal bloating	· Irritability
· Edema and weight gain	· Anxiety
· Headache	· Depression
· Breast tenderness and swelling	· An alteration in sleep, appetite, thirst, libido
· Pelvic discomfort	· Unprovoked anger
· Altered bowel habits	· Difficulty concentrating
· Reduced coordination	· Crying spells
	· Tiredness

Behavioral Changes
Absenteeism
Proneness to accidents
Possibly criminal behavior or suicide

Diagnosis

APA (American Psychiatric Association) Guidelines for the Diagnosis of PMDD-Premenstrual Dysphoric Disorder: (1994)

a. At least five of the following are required, one of which must be one of the first four.
b. The symptoms must interfere with work / school / usual activities / relationships.
c. The problem is not an exacerbation of the symptoms of a chronic condition (e.g., major depressive disorder).
d. The above criteria must be confirmed by prospective daily ratings during at least three consecutive symptomatic cycles to confirm a provisional diagnosis.

- Affective lability (e.g., sudden onset of sadness, tears, irritability, or anger)
- Persistent and marked anger or irritability
- Anxiety or tension
- Depressed mood and feelings of hopelessness
- Decreased interest in usual activities
- Easy fatigability or a marked lack of energy
- Subjective sense of difficulty in concentrating
- Changes in appetite; overeating or food craving
- Hypersomnia or insomnia
- Feelings of being overwhelmed or out of control
- Physical symptoms, such as breast tenderness, headaches, edema, joint or muscle pain, and weight gain

Treatment

As 5-10% of women suffer from PMS that interferes with daily life, women with PMS should be managed correctly. Treatment depends on the severity of the symptoms.

1. General Health Measures
2. Low-risk pharmacologic interventions: (Calcium carbonate, magnesium, vitamin B6, vitamin E, nonsteroidal anti-inflammatory drugs (NSAIDs), spironolactone, bromocriptine)
3. Severe PMS and PMDD: (SSRIs, anxiolytics, alprazolam)
4. Hormonal interventions: (Gonadotropin-releasing hormone (GnRH) agonists, danazol, progestogens, low-dose COC's)
5. "Surgical Menopause"
6. Alternative options for PMS: (Evening primrose oil, psychological methods, self-help groups, herbal remedies like sage, fennel, rosemary, camomile,dandelion)
7. Other approaches like yoga, homeopathy or acupuncture.

How to prevent STIs?

A. Bigrigg (UK)

This discussion was attended by delegates from Brazil, England, Scotland, Spain, Turkey and the United States of America. The meeting agreed that sexually transmitted infection is a major public health problem across the world and that the epidemiology or number of STIs (Sexually Transmitted Infections) recorded were affected by available surveillance systems and tests. The burden of disease fell unequally among sectors of the population due to health inequalities in education and access to services. However, trends in sexual behaviour in the countries represented at the discussion as well as improvements in surveillance systems, were leading to an increase in recorded infection.

Sexual behaviour and developmental trends varied between nations, but a common factor was different gender perceptions of sexual risk. The importance of targeting men with education and behavioral modification regimes was unanimously agreed. Factors that differed between societies included the influence of deprivation on risk-taking behaviour. Within the United Kingdom deprivation is closely linked to early age of first sexual intercourse and teenage pregnancy. Whereas within Turkey, it is believed that risk-taking behaviour maybe more prevalent amongst the educated young people living in urban settings. The importance of a country understanding different sexual behaviour amongst different sectors of its population in order to target both educational and service preventions was noted.

It was agreed by the group that as well as education and information dissemination, the availability of condoms was important. However, most delegates agree that availability had to be linked to health promotion campaigns promoting use. Strengths and weaknesses of different distribution systems was discussed. These ranged from making condoms freely available but in an untargeted and unsupported manner, to C Card Schemes where an individual is given a card entitling them to access free condoms. When the card is issued, a brief education session is undertaken covering how to use condoms and related health matters such as emergency contraception.

Positive actions for both individuals and organisations involved in contraception provision which could be undertaken to help protect our patients against STIs was suggested and include the following:

Individual Clinicians	Health Care Organisations Providing Contraception
· Talk about sex · Discuss risky behaviour · Discuss dual methods · Provide information · Other tests	· Provide STI test and treatment · Ensure STI covered in training courses · Consider screening programmes general population special groups · De-stigmatize STIs

In conclusion, it was agreed that although the sexual risk-taking behaviour differs from country to country, each nation has much to learn from others, and that sessions exchanging practice around sex education and promotion of condom use were informative.

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