EC On Hand Failed to Cut Pregnancy Rates

BY SHARON WORCESTER

Advance provision of emergency contraception is associated with earlier use and increased overall use of EC following unprotected sex, but it does not reduce pregnancy rates, according to the findings of an updated Cochrane Review.

VITALS

Major Finding: Women with EC on hand were no less likely to become pregnant than those who had "standard access." Odds ratios for becoming pregnant ranged from 0.48 to 0.98 for studies with follow-up ranging from 3 months to 12 months.

Data Source: A meta-analysis of 11 randomized controlled trials involving 7,695 women from the United States, China, India, and Sweden.

Disclosures: Two of the Cochrane Review authors were also investigators involved in studies that were included in the review. Ibis Reproductive Health provided support for this study.

Eleven randomized controlled trials involving 7,695 women from the United States, China, India, and Sweden were included in the new review, which is an updated version of a review completed in 2007 with similar findings.

Women in the 11 trials who had EC on hand were no less likely to become pregnant than those who had "standard access," such as counseling and/or access on request, lead researcher Chelsea Polis of Johns Hopkins University, Baltimore, and her colleagues reported online in the Cochrane Database for Systematic Reviews. Odds ratios ranged from 0.48 to 0.98 for studies with follow-up ranging from 3 months to 12 months, respectively.

Compared with those who had standard access, the women with advance access did use EC more often (odds ratio 2.47 for single use and 4.13 for multiple use), and they used it earlier (weighted mean average of 12.98 hours earlier). They also were no more likely to contract a sexually transmitted infection (OR 1.01).

Condom use was the same among those with and without advance access, the investigators found.

Providing EC in advance of need is a common strategy for ensuring that women have access to EC when they need it, but despite earlier optimistic projections of the potential public health impact of improved access, the findings of this review suggest this approach does not reduce unintended pregnancy, Ms. Polis and her associates reported.

Part of the problem is that some women do not use EC even when it is available. Nonuse varied widely across the studies included in the review, and research suggests that a number of factors contribute to the decision to not use EC, including unperceived pregnancy risk, concerns about side effects, and inconvenience, the investigators noted.

Nonetheless, the findings should not preclude women from being provided with advance access to EC, particularly since obtaining EC when needed can be difficult and time-consuming, and because the review suggests that advance access does not negatively impact sexual and reproductive health behaviors and outcomes, they said.

"Women should be given information about and easy access to emergency contraception because individual women can decrease their chances of pregnancy by using this method," Ms. Polis and her associates concluded.

Future research should focus on the reasons behind failure to use EC when needed and available, they said.

Emergency contraception methods included in this review were combined estrogen-progestin, levonorgestrel alone, and mifepristone. None of the studies in the review that compared the regimens showed any difference in outcomes based on method used.

Weaknesses of the review include the unknown validity of reported information on the use of EC, the frequency of unprotected sex, and changes in contraceptive patterns. This information should be viewed with caution, given the lack of objective verification, the investigators said. ■

DRUGS, PREGNANCY, AND LACTATION

Screening for Postpartum Depression

BY LEE COHEN, M.D.

Postpartum depression is a highly prevalent illness, with multiple studies consistently reporting rates of about 7%-10%, which include both minor and major depression. In some countries such as the United Kingdom, screening for postpartum depression is part of standard health care. In the United States, screening is highly variable, although there has been increasing awareness of this illness and the potential value of screening.

Screening for postpartum depression (PPD) has been recommended as part of routine postpartum care by the American College of Obstetricians and Gynecologists (Obstet. Gynecol. 2010;115[pt. 1]:394-5). Several states, including New Jersey, have initiated mandated screening programs in a variety of settings to identify women suffering with postpartum depression. In Maine, an interesting pilot project has been launched, supported by the state's psychiatric association, which entails screening women for postpartum depression by a spectrum of clinicians including obstetricians and primary care physicians, with psychiatric backup by a group of psychiatrists with subspecialty expertise in the management of postpartum depression.

Few would argue about the theoretical value of screening for postpartum depression, particularly when it leads to effective treatment, but very few studies have looked at whether screening is really cost effective. Specifically, it remains unclear whether screening for PPD leads to effective treatment of the illness (remission) and whether over time those treated do better clinically than those who are not identified or treated.

But a study conducted at the University of York (England) took a critical look at the extent to which screening for postpartum depression in a primary care setting was cost effective when a standardized postnatal depression or generic depression screening tool was used. The analysis, using an economic model and a hypothetical population of women seen at 6 weeks' post partum in a primary care setting, determined that screening for PPD was not cost effective and therefore, could not be supported by the National Health Service, based on screening criteria established by that organization (BMJ 2009;339:b5203). The authors determined that the main reason screening was not cost effective was the cost of care for women with false-positive screening results. They concluded that the results did not meet the criteria required for formally adopting such a screening program.

The analysis did not factor in the associated costs of untreated postpartum depression, including the effect on the family and the child, despite the extensive literature on the toll of untreated PPD, including the risk for chronic maternal depression, recurrent postpartum depression, and adverse effects on infant and child development associated with untreated puerperal mood disturbance.

This study, although of interest, was conducted in a country with a national health care system that cannot be entirely extrapolated to the United States. But cost-effectiveness and other issues surrounding the feasibility and overall value of screening for postpartum depression are still relevant issues that need to be considered in this country, as screening increasingly becomes a part of routine postpartum care and as more of these programs are recommended by professional organizations, if not mandated by given states.

For those of us who treat this illness, the question is not whether we can effectively screen for PPD, because screening is a simple process that can be accomplished with well-validated and readily available instruments. And there are extremely effective modalities for getting patients well, including nonpharmacologic interventions, such as certain psychotherapies, and pharmacologic interventions, such as antidepressants. Therefore, the problem that looms largest with respect to instituting screening programs is not what is the most appropriate screen or how to identify women with the illness. Rather, the most challenging aspect of screening for PPD in the United States centers on what follows identification of illness. How do clinicians ensure that identified patients have access to treatment that restores euthymia?

In the United Kingdom, primary care physicians routinely manage postpartum depression with regional backup from clinicians with expertise in reproductive psychiatry. In the United States, some primary care physicians treat postpartum depression, but others may be reluctant to do so, which highlights the contention that until a system is in place that ensures treatment of the illness following screening, then it may not be advisable to rush to institute such a program.

A critical question also yet to be addressed is whether early identification of postpartum depression translates into a positive long-term outcome. We need to collect data on what happens after women are diagnosed, whether they get treated, and if so, how they are treated—with psychotherapy or pharmacotherapy. Data are also needed on who provides treatment and what types of treatment appear to be most effective for which types of patients. And when patients do get well, we need to look at data on whether the improvement is sustained. The precise value of screening is impossible to determine until we have these data.

If there ever is a national mandate to screen for postpartum depression, then it is critical to demonstrate that we have a treatment model in place that not only identifies patients who suffer from the illness, but that such a system includes delivery of effective treatment. Lastly, while it currently may not be possible to quantify the benefits of a screening program for PPD, what *is* clear is that such a program might help to destigmatize mental illness and prompt patients to seek treatment from a variety of care providers, including primary care physicians and obstetricians. Perhaps with greater opportunities to receive effective treatment from a variety of clinicians, the morbidity of postpartum mood disturbance could be vastly limited.

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