

PROPHYLACTIC LOW DOSE OCPS (V/S) ANTIPROSTAGLANDIN IN IUCD USERS

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SUMMARY

Continuous use of contraceptive depends mainly on convenience, efficacy and absence of side effects along with good counselling. One hundred consecutive cases of IUCD at the time of insertion were put on prophylactic low dose OCPs/NSAIDs for three cycles to take care of the two main side effects i.e. menorrhagia and dysmenorrhoea. This policy resulted in dramatic reduction in the side effects along with next to nil removal on demand and expulsion rates in both groups. Thus possibility of putting the IUCD clients on prophylactic treatment at the time of insertion can be explored in a larger series. All these insertions and counselling of every case were done by a single doctor which might also play some role as to the technique of insertion, patient selection and counselling.

INTRODUCTION

Continuation of contraceptive use depends on the convenience and the absence of side effects. Intrauterine contraceptive devices (IUCD) are relatively popular in India but suffer from high rate of discontinuation in the 1st year of use.

Discontinuation rates up to 22.6% are reported from expulsions and removal for medical indications (Piotrow, 1979). Menorrhagia and dysmenorrhoea led to 8.5/100 removal in Cu-T200. This study was designed to : a) see the impact of prophylactic treatment for menorrhagia and dysmenorrhoea, on the discontinuation rate of IUCD and b) to compare the efficacy of non-steroidal anti-inflammatory drugs

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(NSAID) and oral contraceptive pills (OCP) in control controlling line menorrhagia and dysmenorrhoea. after one year.

MATERIAL AND METHOD

One hundred consecutive clients inserted with IUCD were put on prophylactic low dose OCPs or mefenamic acid (500) mg/diclofenac sodium (50) mg three times a day for seven days. The allocation in the two groups was according to the patient's choice. OCPs were started on the day of insertion and cyclically taken for 3 cycles. NSAIDs were given on insertion for 7 days and subsequently premenstrually when the patient had feeling of lower abdominal and back pain for 3 more cycles.

Eighty six patients turned up for follow up after one month and 79

OBSERVATION

Prior to this study discontinuation rate for IUCD in our centre was around 20%. Out of 100 clients in the present series 65 opted for IUCD at the time of medical termination of pregnancy. Remaining 45 came for contraceptive counselling and chose IUCD, 24 chose OCPs as the prophylactic drug and 76 opted for NSAIDs. Eighty six turned up for follow up after one month and 79 after one year. Rest were lost to follow up. None of the troublesome side effects were present after 1 month in the two groups. Only one patient had mild dysmenorrhoea in NSAID group after one year but did not demand removal. Removal of IUCD was required in one patient in

Table I
FOLLOW UP OF PATIENTS ON PROPHYLACTIC TREATMENT

Prophylactic	Low Dose OCPs X 3 Cycles	NSAID 7 days X 3	Total
No. of Patients	24	76	100
Follow up after 1 month	20	66	86
Menorrhagia and dysmenorrhoea	none	none	
Expulsion	none	none	
Removal on demand	none	none	
Follow up after 1 year	18	61	79
Menorrhagia and dysmenorrhoea	none	one (mild)	
Expulsion	none	none	
Removal demanded	1	none	

OCP group who was planning for pregnancy and the surprising fact was none had spontaneous expulsion of IUCD (Table I). All the insertions were done by the same doctor.

DISCUSSION

Continuation rates of IUCD can be highly enhanced by giving prophylactic treatment for dysmenorrhoea and menorrhagia which are the two, rather common associates with IUCD insertion. Decrease in frequency and/or severity of menstruation is highly acceptable in females of developing countries who are living on a marginal level of nutrition and are already anaemic with socially restrictive taboos during menstruation (Short 1979). Both the therapeutic modalities are equally effective for these symptoms in our series. Mefenamic acid inhibits cyclo-oxygenase enzyme system and inhibits the binding of PGE to its myometrial receptors (Rees et al, 1988) resulting in reduction in blood loss.

Low dose OCPs not only reduce the loss of blood but also provide a regularity to menstrual cycles which is highly appreciated by females. Reduction in dysmenorrhoea increases its acceptability. Induction of endometrial atrophy and reduction of PG release from endometrium may play a part in reducing MLB (Chan and Dawood, 1989).

Thus prophylactic low dose OCPs/ antiprostaglandin for initial 3 cycles along with good counselling can reduce the main side effects of IUCDs leading to very high continuation rates. Certain so called spontaneous expulsions may be voluntary pulling of the IUCD by the patient in initial months due to trouble-some side effects.

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