

Finally, service delivery organization and provider behavior are stronger determinants of the final recorded success of regimens that, pharmaceutically, are more than 90–95% effective. Thus, research and programmatic efforts are best focused on provider training and methods to reduce unnecessary interventions and to increase convenience for women.

The debate is no more, the controversy is settled: 200 mg mifepristone is the regimen of today.

Caitlin Shannon  
Beverly Winikoff  
Gynuity Health Projects  
New York, NY 10010, USA  
E-mail address: [cshannon@gynuity.org](mailto:cshannon@gynuity.org)

doi:[10.1016/j.contraception.2009.08.012](https://doi.org/10.1016/j.contraception.2009.08.012)

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## BMI and OCP failure

To the Editor:

The article by Burkman et al. [1] adds to the growing body of evidence exonerating obesity as a risk factor for hormonal contraceptive failure. Consistent with the majority of previous case reports and cohort studies, the association between BMI and unintended pregnancy is either nonsignificant or very weak. With most self-reported data, there is no attempt to control for pill compliance. We performed a secondary analysis of a cohort of 2205 women enrolled in a preterm labor study, using the same methodology, examining the obesity question from a slightly different perspective: calculating the time to pregnancy, stratified by BMI, and controlled for confounders such as smoking, exercise, age and race/ethnicity [2]. There was no difference by either BMI category or obese/nonobese dichotomy. Despite its many endocrine perturbations, adipose tissue appears not to affect conception, either desired or undesired.

Susan Richman  
Yale University School of Medicine  
New Haven, CT, USA  
E-mail address: [srichman.summit@gmail.com](mailto:srichman.summit@gmail.com)

doi:[10.1016/j.contraception.2009.09.003](https://doi.org/10.1016/j.contraception.2009.09.003)

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- [1] Burkman RT, Fisher AC, Wan GJ, Barnowski CE, LaGuardia KD. Association between efficacy and body weight or body mass index for two low dose oral contraceptives. *Contraception* 2009;79:424–7.
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## Response to Letter to the Editor by Susan Richman regarding Burkman RT, et al. *Contraception* 2009;79:424–7

To the Editor:

I would agree that the risk of hormonal contraceptive failure may be low among obese women, but this is supposition not based on a firm scientific basis. As noted, the literature to date has been conflicting regarding the role of obesity in hormonal contraception failure. Almost all of the published data is from observational studies with their inherent confounding and biases. Most studies are underpowered, including our study, to thoroughly answer the question. The study of Richman [1], although interesting, is also observational and does not directly address whether hormonal contraceptives with therapeutic levels of steroids are associated with a higher failure rate among obese women. In addition, adding to the confusion is the variation in types of hormones particularly progestins, the various dosages formats, the length of hormone-free periods and the use of progestin without estrogen. As we note in our article [2], to better answer the question will require a randomized clinical trial with a large sample size. Because of the growing rate of obesity in this country, it is an important question to answer along with whether the risk of serious sequelae is substantially different.

Ronald T. Burkman  
Baystate Medical Center  
Springfield, MA, USA  
E-mail address: [rtb@bhs.org](mailto:rtb@bhs.org)

doi:[10.1016/j.contraception.2009.09.002](https://doi.org/10.1016/j.contraception.2009.09.002)

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## Letter in response to the article “Accuracy of information given by Los Angeles County pharmacies about emergency contraception to sham patient in need”

To the Editor:

The recent article titled “Accuracy of information given by Los Angeles County pharmacies about emergency

contraception to sham patient in need” [1] raises serious questions about pharmacists’ knowledge about emergency contraception (EC) and the consumers’ access to timely and accurate information. Yet, it cannot be overstated that the majority of pharmacists who were available to respond to the sham patient’s call took time to ensure that accurate information was provided. Clearly, the survey highlights the need for more EC education regarding its use and benefit to women trying to prevent an unintended pregnancy. And as cited in the January/February issue of the *Journal of American Pharmacists Association* [2], most US pharmacists view access to contraceptive information as an important health care issue. Still, it is imperative that pharmacists, as well as all medical professionals, have the tools necessary to give women timely and accurate information about EC. The Pacific Institute for Women’s Health and Pharmacy Access Partnership have long held that access to EC is not only about education and awareness; it is about cost and availability — a reproductive justice issue that cries out for a recommitment of needed resources from the public health and philanthropic communities.

Belle Taylor-McGhee  
*Pacific Institute for Women’s Health*  
*Oakland, CA 94610, USA*  
*E-mail address: [btmcghee@piwh.org](mailto:btmcghee@piwh.org)*

doi:10.1016/j.contraception.2009.03.016

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## Letter in response to Belle Taylor-McGhee

To the Editor:

I want to thank Belle Taylor-McGhee for her comments. However, we do not want to choose between education and of rapid accessibility; our patients need them both. The approval of Plan B without a prescription has definitely increased the potential availability of emergency contraception (EC) to women in need. As a condition of approval for the so-called behind-the-counter status, the FDA required that the manufacturer work closely with pharmacy groups to ensure that their members provided accurate information to potential users. These extensive education efforts have borne fruit. As our survey demonstrated, the vast majority of pharmacies we contacted provided accurate information; some were so deeply concerned about timely patient access to Plan B that they offered to stay open late. However, some of the pharmacy staff (not necessarily the pharmacist themselves) were rude and/or provided misinformation. As clinicians, this work should remind us not to rely on the patient to seek out her EC in her moment of need. We need to continue to educate our patients about their need for EC and to write prescriptions for it in advance of need. As Dr. Taylor-McGhee points out, cost is an important part of the equation. In most cases, women have to pay out-of-pocket for EC when they buy it without a prescription, but often insurance will help defray the cost if it is purchased with a prescription. Of course, another way to solve the huge problem of unplanned/unprepared for pregnancies would be to prescribe to more women the more reliable methods—such as IUDs and implants. But that is another study...

Anita L. Nelson  
*Department of Obstetrics and Gynecology*  
*David Geffen School of Medicine at UCLA*  
*Harbor UCLA Medical Center, Box 472*  
*Torrance, CA 90509-2910, USA*  
*E-mail address: [anitanelsonwhc@earthlink.net](mailto:anitanelsonwhc@earthlink.net)*

doi:10.1016/j.contraception.2009.03.011