

Obstetrics and gynaecology

Active surveillance vs immediate treatment for CIN2

Active surveillance may be a suitable option in selected, particularly younger, women with CIN2, a systematic review and meta-analysis has concluded.

Medline, Embase and CINAHL databases were searched for studies reporting on outcomes of CIN2 managed conservatively for at least three months, published between 1973 and 2016.

Of 250 potential studies 36 met the eligibility criteria. They included data on 3,160 women with histologically confirmed CIN2. Seven studies were randomised controlled trials, 16 were prospective and 13 retrospective cohort studies. The study sizes ranged from 12 to 924 subjects, and follow-up data were collected for 3 to 72 months (median 16 months).

The most typical follow-up consisted of 3-4 monthly colposcopic and cytological examination, with cervical biopsies performed either routinely or when progression was suspected. There was considerable heterogeneity between studies.

Regression, persistence and

progression rates are shown in table 1, below. In younger women (under 30) the regression rate was 38% at 6 months and increased with the duration of observation to 60% at 24 months. Regression was less common and progression of disease more common in older women. In older women rates of disease progression were higher the longer the period of observation.

Overall, 15 cases of adenocarcinoma in situ were identified during follow-up. There were also 15 cases of invasive cervical cancer (15/3,160, 0.5%) all but two of which were stage 1A1.

A sub-analysis looked at default from follow-up rates in selected retrospective studies. The rates were 19% (95% CI: 7-35%) at 6 months, 15% (95% CI: 6-25%) at 12 months and 8% (95% CI: 1-21%) at 24 months.

Until further data is forthcoming, let us hope gynaecologists factor in future obstetric potential when managing women with CIN2, and consider diligent active surveillance, where appropriate, in carefully selected women.

The study authors state: 'Our results show that active surveillance is justified in selected women with untreated, histologically confirmed CIN2 lesions, particularly if they are young and the likelihood of compliance with follow-up is high.'

However, the author of an accompanying editorial¹ cautions: 'Knowledge of the rates of regression from CIN2 are reassuring but they must be presented in a meaningful way alongside clear information about the effects of both surveillance and treatment, so women can make fully informed choices.'

She adds: 'Knowing that the chance of regression is 50-60% still means taking a gamble that surveillance is simply delaying treatment. Even a small risk of cancer (0.5% in this study) may still be unacceptable to some.'

DR CHRIS BARCLAY

Tainio K, Athanasiou A, Tikkinen KAO et al. Clinical course of untreated cervical intraepithelial neoplasia grade 2 under active surveillance: systematic review and meta-analysis. *BMJ* 2018;360:k499

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Paediatrics

Emollient bath additives of little benefit in childhood eczema

A multicentre pragmatic randomised trial of the clinical effects of emollient bath additives (EBAs) in children with eczema has concluded that their benefits are at best limited.

Overall 483 children with eczema, aged 1 to 11 years, were enrolled in the trial from 96 practices in England and Wales. Children with very mild or inactive eczema over the past year were excluded. All participants had a Nottingham eczema severity score >5¹ and had a bath at least once a week. A total of 265 were randomised to using EBAs and 218 to not using EBAs for a one-year period. The mean age of children was five years in both groups.

Table 1

Pooled rates of regression, persistence and progression of CIN2 managed by active surveillance

Overall outcomes	6 months	12 months	24 months
Regression	52% (95% CI: 36-68%)	46% (95% CI: 36-56%)	50% (95% CI: 43-57%)
Persistence	34% (95% CI: 29-40%)	29% (95% CI: 17-43%)	32% (95% CI: 23-42%)
Progression	13% (95% CI: 8-20%)	14% (95% CI: 9-20%)	18% (95% CI: 11-27%)
Outcomes in women under 30	6 months	12 months	24 months
Regression	38% (95% CI: 21-57%)	51% (95% CI: 40-63%)	60% (95% CI: 57-63%)
Persistence	36% (95% CI: 29-43%)	31% (95% CI: 15-49%)	23% (95% CI: 20-26%)
Progression	18% (95% CI: 12-23%)	9% (95% CI: 2-20%)	11% (95% CI: 5-19%)

Standard advice on leave-on emollient and soap substitute use and use of topical steroids was given to both groups.

The primary outcome was severity of eczema measured each week using the Patient-Oriented Eczema Measure (POEM) questionnaire.² Higher scores equate with more severe disease.

There was one withdrawal in the EBA group. There was no significant difference in POEM scores between the groups at 16 weeks. The POEM score was 0.41 points higher in the no-EBA group (95% CI: -0.27 to -1.10). Only scores >3 points are considered clinically significant.

Secondary outcomes were measured up to 52 weeks and included adherence to protocol, dermatitis family impact, quality of life measures, as well as number of eczema exacerbations, use of topical corticosteroids and topical calcineurin inhibitors (e.g. tacrolimus, pimecrolimus). No significant differences between the groups were identified. Protocol adherence was high in both groups.

Although no overall benefit was seen in the EBA group it is possible that EBAs may have had limited benefit in very frequent bathers (more than five baths per week), and in children under five years of age. The POEM scores in the no-EBA children in these sub-groups were 2.27 points (95% CI: 0.63-3.91) and 1.29 (95% CI: 0.33-2.25) higher respectively. However, the number of children in these subgroups was small. No significant difference in POEM scores with EBA use was observed between children with moderate or severe eczema.

No statistically significant difference in side effects was seen between the groups either.

Currently the mainstay of childhood eczema management requires the regular application of topical leave-on emollients, the use of soap substitutes, and the use of EBAs. While the evidence for the first two is robust that for the use of bath emollients is thin.

These findings suggest that EBAs are neither clinically effective nor cost effective. It has been estimated that EBAs account for one third of the cost of eczema treatments in the UK.

The study authors conclude: 'This trial provides strong evidence that emollient bath additives provide minimal or no additional benefit beyond standard eczema care in the management of children with eczema.'

They add: 'We cannot exclude the possibility of a small benefit among children bathing more than five times

a week or among children aged less than five years, but differences are sufficiently small to be unlikely to be useful.'

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Santer M, Ridd MJ, Francis NA et al. Emollient bath additives for the treatment of childhood eczema (BATHE): multicentre pragmatic parallel group randomised controlled trial of clinical and cost effectiveness. *BMJ* 2018;361:k1332

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Sexual health

Exploring the barriers to fitting IUCDs in primary care

A general practice study has revealed a reluctance among GPs and practice nurses to fit intrauterine contraceptive devices (IUCDs).

An online survey was sent to 69 practices in the south east of England and 208 individuals responded. More than two-thirds of the respondents were GPs and nearly a third were nurses.

A third of respondents (33.6%) reported training in IUCD fitting but 13.2% did not fit IUCDs in their current role. Those trained in IUCD fitting were more likely to work in practices that were commissioned to provide IUCD services.

When asked about statements relating to potential barriers to providing or recommending IUCDs, respondents who were not trained to fit IUCDs were more likely to identify with more barriers than those who had been trained.

There was an apparent dissonance between respondents' knowledge

about the suitability of IUCDs for some women and actually recommending IUCDs to these patients. Even though most felt that more women could be using IUCDs, they did not feel that they could recommend their use to younger or nulliparous women, unless other methods had failed. Virtually all respondents (97%) agreed with the statement 'IUCDs can be used in all patients with no previous pregnancies' but fewer than two thirds (63%) would recommend them to nulliparous women. Likewise, three-quarters of respondents agreed that 'Currently available IUCDs are suitable for all ages' but under half (42%) would recommend them to teenagers.

Four themes were identified from the qualitative study: proactive selection of women, risk aversion, assumption of what women wanted and confidence and competence with respect to fitting IUCDs.

There was a perception that IUCDs were riskier in terms of risk of infection, or more difficult to fit for certain types of women. The perception that IUCD fitting was a risky procedure was identified as a strong theme. Some thought IUCD fitting could lead to complaints or even litigation.

Many assumed that patients had already made their minds up about what type of contraception they wanted, and some had adverse views about IUCDs. Hearing women's negative experiences about having an IUCD fitted also made them feel more reluctant to recommend them.

The cost of, and access to, training to fit IUCDs was a barrier but some respondents thought that there might not be enough demand from patients to justify it and to maintain competency sufficiently.

I agree with the authors that education and training especially for those not trained to fit IUCDs might address some attitudinal barriers to recommending them to patients, particularly as some perceptions about acceptability and suitability of IUCDs were not based on evidence.

DR RICHARD MA

Hoggart L, Walker S, Newton VL, Parker M. Provider-based barriers to provision of intrauterine contraception in general practice. *BMJ Sex Reprod Health* 2018; 0:1-8. doi:10.1136/bmjshr-2017-101805

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