NONOXYNOL-9 DOES NOT PREVENT SEXUALLY TRANSMITTED INFECTIONS

Wilkinson D, Tholandi M, Ramjee G, Rutherford GW. Nonoxynol-9 spermicide for prevention of vaginally acquired HIV and other sexually transmitted infections: systematic review and meta-analysis of randomized controlled trials including more than 5000 women. Lancet Infect Dis 2002;2:613–7.

Nonoxynol-9 has been used, with and without condoms, as a method of preventing the transmission of sexually transmitted infections (STIs). However, the World Health Organization (WHO) recently issued a report declaring nonoxynol-9 ineffective for this use.[1] This meta-analysis includes some of the data that led to the WHO recommendation.

Nine trials were included in the analysis. Participants included sex workers with high rates of human immunodeficiency virus (HIV) who received regular STI screening and treatment. Only two studies showed use of nonoxynol-9 to be protective against chlamydia and gonorrhea, and both of these had small effects. None of the trials demonstrated protection against HIV, and the risk of HIV was greater with use of nonoxynol-9, although the difference was not statistically significant (RR 1.12, 95% CI 0.88–1.42). The risk of genital lesions was significantly greater with the use of nonoxynol-9 (RR 1.19, 95% CI 1.02–1.36).

In summary, nonoxynol-9 has no benefit in preventing HIV and STIs, and it may cause harm. Whether nonoxynol-9 enhances the contraceptive efficacy of other methods (e.g., condoms) remains unclear. For now, male condoms remain the most effective way to prevent HIV and STIs and should be recommended to all persons at risk of infection. In addition, products containing nonoxynol-9 should not be used rectally because of the detrimental effect of the microbicide on the rectal epithelium.[1]

REFERENCE

1. WHO/CONRAD technical consultation on nonoxynol-9: Summary report. 2001 October 9–10, Geneva, Switzerland. Geneva: World Health Organization; 2002. Available from: http://www.who.int/reproductive-health/rtis/nonoxynol9.html.

THE EFFECT OF PACIFIERS AND SUPPLEMENTAL FEEDING ON BREASTFEEDING

Howard CR, Howard FM, Lanphear B, Eberly S, deBlieck EA, Oakes D, et al. Randomized clinical trial of pacifier use and bottle-feeding or cupfeeding and their effect on breastfeeding. Pediatrics 2003; 111:511–8.

Although the World Health Organization and many professionals discourage the use of pacifiers and supplemental feedings, there is little evidence to support the detrimental effect of artificial nipples and cup-feeding on breastfeeding. Howard et al. conducted a randomized trial to explore this relationship.

This trial included 700 breastfed newborns born at 36 to 42 weeks gestation with weights of 2,200 g or more at birth. Infants were randomized to receive cup or bottle-feeding if supplementation was needed and randomized to early (2–5 days) or late (>4 weeks) pacifier introduction. Thus, there were 4 study groups: bottle/early pacifier, bottle/late pacifier, cup/early pacifier, and cup/late pacifier. Data on breastfeeding were collected at birth and then at 2, 5, 10, 16, 24, 38, and 52 weeks postpartum. Breastfeeding duration was defined as exclusive (no supplementation, full), less than daily supplementation, and overall (any breastfeeding). Supplementation, via bottle or cup, was given to 69% of the entire cohort. The reason for supplementation was medical for 33% of the infants, at the mother's request for 51%, and not documented for 16%.

Supplemental feedings via either cup or bottle were associated with decreased rates of exclusive or full breastfeeding at 1 month. The most significant predictor of all types of breastfeeding duration was supplemental feeding in the hospital. Cup-feeding was preferable to bottle-feeding in promoting breastfeeding duration, and pacifier use during the first 4 weeks decreased exclusive breastfeeding at 1 month of age.

One of the most striking features of this study was the reason for supplementation. At least half of the time it was done at the mother's request. Although additional evidence is needed to definitively assess the negative impact of supplementation, it appears there is some effect. Educating mothers about when supplementation is necessary could decrease this practice and perhaps enhance continued breastfeeding.

DOES TREATMENT OF ABNORMAL GENITAL TRACT FLORA DECREASE THE RISK OF PRETERM BIRTH?

Lamont RF, Duncan SLB, Mandal D, Bassett P. Intravaginal clindamycin to reduce preterm birth in women with abnormal genital tract flora. Obstet Gynecol 2003;101:516–22.

Ugwumadu A, Manyonda I, Reid F, Hay P. Effect of oral clindamycin on late miscarriage and preterm delivery in asymptomatic women with abnormal vaginal flora and bacterial vaginosis: a randomised controlled trial. Lancet 2003;361:983–8.

Preterm birth is one of the most significant causes of morbidity and mortality in modern obstetrics, yet extensive research has failed to decrease its prevalence in recent years. There is good evidence that abnormal flora in the genital tract and particularly bacterial vaginosis are associated with preterm birth. What remains less clear is whether treatment of these conditions can prevent preterm birth

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