EDITORIALS

Should depot medroxyprogesterone acetate be considered for additional uses?

ROBERT A. H. KINCH,* MB, FRCS[C], FRCOG

Depot medroxyprogesterone acetate (DMPA) (Depo-Provera, Upjohn Company of Canada) is cleared in Canada for use in the management of endometriosis in the nonpregnant woman and for palliation of advanced endometrial cancer. There has been a question as to whether physicians are authorized to use this drug for other clinical conditions. The health protection branch of the Department of National Health and Welfare has stated that the limitation of indications establishes constraints on a pharmaceutical manufacturer’s promotion and advertising of a drug. This, however, does not interfere with the right of physicians to use the drug for other indications when, in their assessment, the benefits outweigh the risks. Medical judgements of this type are an integral part of the practice of medicine, which is regulated in each province by a licensing agency.

After a review of the world literature and data on the clinical use of this drug for indications other than those mentioned, the health protection branch’s special advisory committee on reproductive physiology, a group of nongovernment consultants, has concluded that the available clinical experience with DMPA shows a favourable risk/benefit ratio and that the drug does not present an undue health hazard.

Experience with DMPA for contraception has totalled more than 10 million women-years since the first clinical studies began in the early 1960s. It is estimated that more than 1.2 million women in various countries are presently using DMPA for contraception and that several thousand women have used it for contraception for 10 years or more. No contraceptive method is entirely risk-free, and any consideration of safety must take into account the risks of other methods. Presently available data indicate that the risk/benefit ratio for DMPA in an appropriately selected population is as favourable as that for oral contraceptives or intrauterine devices.

Many international organizations concerned with family planning have supported these statements. The International Planned Parenthood Federation’s medical advisory panel, which consists of eminent scientists, has endorsed the recommendations of the World Health Organization, the ad hoc committee panel of the United States Agency for International Development on DMPA and the scientific advisory committees of the US Food and Drug Administration by stating that “it continues to be a responsible act to make Depo-Provera available as a contraceptive”.

Our committee reviewed the October 1981 publication concerning the use of DMPA in the Ontario government facilities for the mentally retarded. Its authors considered “of borderline significance” the finding of three deaths from carcinoma of the breast in 533 women treated with DMPA at some time during their lives. The evidence for a causal relationship is very tenuous.

We have grave concern over the wide publicity that this report has received, for there are questions about its validity, as the authors repeatedly noted. The composition of the study cohort and the control group as well as the incomplete collection of data make the statistical evaluation questionable. In addition, the higher prevalence of carcinoma of the breast in mentally retarded individuals and in patients with epilepsy and the fact that the other medications many of these patients must have received were not reported or commented upon further confuse the issue and invalidate the inferences. We also note from our review of the world literature that among 11 500 DMPA users in the United States there have been only four reported cases of carcinoma of the breast, for a rate that is lower than that expected in a Canadian control population.

Since there are no findings comparable to those of the Ontario report in the world literature or in the data supplied by Upjohn to the health protection branch, we reaffirm our opinion that DMPA is safe in the management of specific clinical problems. We believe that there is no undue health hazard when DMPA is used to produce amenorrhea in physically or mentally handicapped individuals unable to cope satisfactorily with menstrual hygiene. In our opinion it may also be useful in women for whom other forms of contraception are considered medically undesirable or inappropriate, or when an oral contraceptive regimen is contraindicated or too demanding; this applies to women who do not want either future pregnancies or sterilization. We believe that the woman, with her physician’s advice, is in the best position to judge the suitability of a particular contraceptive method. Her decision should be fully informed and free of coercion.

The opinions expressed here are those of the special advisory committee and not necessarily those of the health protection branch. Data supporting the safety and efficacy of DMPA for indications other than the management of endometriosis in the nonpregnant woman and palliation of advanced endometrial cancer have not been formally submitted to the health protec-

*Chairman, special advisory committee on reproductive physiology, health protection branch, Department of National Health and Welfare, and professor and chairman, department of obstetrics and gynecology, McGill University, Montreal

Reprint requests to: Dr. Carl E. Boyd, Executive secretary, Special advisory committee on reproductive physiology, Rm. 310, 355 River Rd., Vanier, Ont. K1A 1B8

CMA JOURNAL/NOVEMBER 15, 1982/VOL. 127 947
The history of medicine, a subject of interest to an increasing number of people, does not belong exclusively to either medicine or history. It is a multidisciplinary subject appealing to persons of different backgrounds and interests because of their common interest in medicine. Medicine's past is a key to those who are concerned about today's medicine; it is also a fascinating part of general history. Thus its readers include historians and sociologists as well as health scientists, medical practitioners and government representatives. Similarly, those who write about medical history come from various backgrounds, and they experience different types of problems in pursuing their research. A few suggestions here may help CMAJ readers to produce even better writings on the history of medicine.

The most obvious contribution a physician may make to the history of medicine is to prepare the biography of another physician or an autobiography, to write the story of a hospital or other organization dealing with health or disease, or to chronicle the development and achievements of a medical specialty, school of thought, faculty or project, or the celebration of some anniversary. However, these are not the only areas. Many physicians, for instance, have been questioned by historians not trained in medicine to interpret medical facts or to confirm the validity and acceptability of a theory or opinion. Many histories written by nonphysicians would benefit from this type of consultation and advice.

Many CMAJ readers have written about the history of their own special area in medicine, and many of these articles have made a substantial contribution to the history of medicine. Numerous other physicians have, at some time during their careers, resolved that when they have the time they will record their impressions or analyses for the written page. Other physicians have found nostalgia a spur to writing as they grow older — not so much because they want to record thoughts about the good old days, but rather because they believe some knowledge will be lost if it is not recorded. This is particularly true of biography and institutional history.

Whatever the subject and the motivation, the physician preparing a historical account comes to realize the factors that will hinder completion of the task. Paradoxically, hindrances may stem from strengths of the physician's professional career: preparing succinct summaries of recent happenings does not give a physician an appreciation for the historical perspective. In addition, the history of medicine as a subject has not received sufficient attention in our medical schools, and physicians may never have had the time to read widely in medical history.

Because researching and writing history of medicine is different from similar activities in medical and clinical science, physicians should consider seeking advice and help from a professional historian. Of the 16 Canadian medical schools 8 have a professional medical historian on their faculty, and nearly every university history department has someone interested in the history of medicine who is competent to advise about historical methods.

A book that is often suggested as helpful to the amateur historian is Edwin Clarke's "Modern Methods in the History of Medicine" (Athlone Press, University of London, 1971). Professional historians may suggest other works on historical methods to assist the troubled would-be historian. Physicians should avoid the temptation to react to difficulties by putting the work aside, never to take it up again. That would be a great loss.

Before beginning to write a medical biography or history of an institution or specialty it would be well to read a number of examples of such writings.

A specific portion of the project should be selected and prepared as a paper for presentation to a suitable meeting, perhaps the annual meeting of the Canadian Society for the History of Medicine. This will provoke helpful criticism at the meeting and be useful as an exhibit when applying to a granting agency for research funds.

Whatever you decide to write, spend a little time in preparing for the effort. The time will be a good investment, and the resulting work will be better. History of medicine, of interest to so many, deserves this special attention.