Sixty Years After the Pill, Medicine Still Needs To Make Progress

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Some of us remember the first years of availability for oral contraceptives. When Chang, Pincus, and Rock developed the oral contraceptive in 1959 and marketed it as Enovid in 1960, it changed everything for women, men, and families.[1] Since that time, choice of spacing of children and family size also has changed the world. According to the World Bank, birth rates worldwide are 50% of what they were in 1960, and smaller families have had a profound effect on economies in the developing world and on the educational attainment of women.[2] The story is well known and a remarkable measure of success in the 20th Century.

Intrauterine devices (IUD) were developed in the late 1960s and early 1970s and, along with barrier devices such as vaginal diaphragms and cervical caps, gave more options to women who, for various reasons, would not or could not use oral contraception. I learned to insert IUDs in the mid-1970s. While the first versions had real problems, they represented an advance in choice. With the advent of copper IUDs and progesterone-imbedded devices, both the long-term stability and the lessening of side effects made family planning a possibility for even more women.

When implantable hormonal subdermal agents came along as the next long-acting reversible contraceptives (LARC), there was promise that these agents would decrease unplanned pregnancies even more but, more importantly, would be used by women who had many other objections to what had been available, because LARCs did not require adherence to daily doses of medications.

In this issue of *WMJ*, a review of the biology and use of LARCs with explanations of different methods by Baron, Potter, and Schrager assesses issues of access, possible barriers, and insurance coverage with IUD and hormonal implants in Wisconsin.[3] Their review serves as an excellent primer for clinicians who need to understand the action of LARCs and some of the common misunderstandings about their use–timing and primary and secondary effects.

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Olson and colleagues report on a survey they carried out in the state asking obstetrician-gynecologists, family physicians, and pediatricians about their training and comfort using LARCs with their patients.[4] While Ob-gyn clinicians, including midwives, are trained and use LARCs at a high level, pediatricians have low levels of training and use, and approximately 45% of family physicians are trained and use them. The barriers are those of training–family physicians generally do not get training in LARC provision, with the possible exception of IUDs. In all situations, clinicians have more comfort with IUD insertion than the hormonal implants, which might present problems if patients would prefer not using IUDs. While they found no difference between urban and rural clinicians, since family doctors are the primary source of contraceptive care in rural communities, that may create problems for women who would choose LARCs as their contraceptive choice. More training, more information, more skills, and more devices in stock are what is necessary to increase the use of these very effective methods of contraception. However, access to services is confounded by distance and availability of clinicians for rural women as well as insurance coverage and clinicians who will accept Medicaid for low-income women. Training by itself isn't enough.

Once in a while, journal editors come across an article that is not only informative about clinical medicine but also a delight to read. Waclawik writes about the history behind the syndrome of progressive areflexic paralysis, Guillain-Barré syndrome, which he argues might have been called Guillain-Barré-Strohl syndrome, and how its diagnosis has changed since its original description over 100 years ago while retaining the clinical picture that they so clearly described.[5] Ironically, with the Zika virus outbreak and the increase in Guillain-Barré syndrome as a consequence, it has been

in the news a great deal. It may be more clinically correct to not use eponyms for syndromes and diseases, but their persistence in clinical medicine is not only a rationale for dredging up long lost medical school notes but also are fun to use with younger physicians. So when someone inquiries about Guillain-Barré, refer them to Waclawik's article and enjoy.

Three case reports highlight issues to be aware of–as they always do if written well and include a review of the literature as part of the article. Riaz and Dolan describe a man whose diabetes worsened and was increasingly difficult to control and, when his physicians looked at his pancreas, was found to have pancreatic cancer.[6] The lesson is that we should consider other sources for difficult to control diabetes and in that differential, which we all memorized in residency, include pancreatic cancer.

The second case report, by Tak and colleagues, describes a possible familial link to Tako-tsubo cardiomyopathy–the broken heart syndrome.[7] As in so many clinical situations, a good family history can suggest approaches that may not have been thought of from a straight history and physical.

The third case from Marzlin and colleagues is one that describes an unusual clinical presentation in an elderly woman whose dyspnea increased and oxygen saturation decreased when she sat up or stood, with no evidence of increasing heart failure. She was diagnosed with platypnea-orthodeoxia syndrome from an atrial septal defect and recovered post closure. The clinical presentation was the key to the diagnosis—another reason to continue to emphasize physical diagnosis in medical education.[8]

Polewski describes how a resident-led group that, over 3 years, has produced a "colleague to colleague" confidentiality and provided permission to be vulnerable with each other.[9] "Tears were shed, hugs were given, jokes were made, and food was eaten," he writes. This strategy should be institutionalized in his own system and everywhere else. It is an antidote to the professional isolation and loneliness that has become a larger and larger part of professional life.[10]

Finally, Connelly and List describe a pilot program to teach residents about personal finances during and post residency.[11] I remember being asked at my first job what I wanted to do for retirement funds and knowing nothing about the value of various choices. I also have a colleague who loves to regale friends with "triple D stories"–or Dumb Doctor Deals about physicians being duped by shady investments. While one can only go so far in the prevention of stupidity, teaching young doctors how to think about their financial futures through basic education in financial planning seems like a good investment–pun intended.

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