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Letters to the Editor

When did family planning become a risky proposition?

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To the Editor:

In "Title X: A Proud Past, An Uncertain Future," Coleman and Jones [1] describe a robust family planning network that was created and maintained in a politically divisive environment. The legislators who crafted Title X 40 years ago kept the focus on their constituents and were able to create centers where "no one is turned away." This is a true safety net—policy that delivers on the promise of bringing family planning to all who need it and want it. If they could do it then, why has contraception become such a divisive issue today?

It appears that family planning has become a risky proposition in today's congressional climate because of a lack of political will. During the 2011 budget stalemate in which Title X was almost de-funded, it became clear that the divide was all about politics. This model program that makes contraception available for all became a political football. Both Democrats and Republicans revealed that the right of poor and vulnerable families to determine whether and when to have children came a clear second to partisan squabbling.

The bitter politicking did not stop in 2009. In August 2011, the Department of Health and Human Services saw fit to allow religious exemptions to the new guidelines that would cover contraception as preventive care in every person's health insurance.

As the leader of a Catholic organization, I know that our Catholic commitment to the most vulnerable requires us to stand with them—especially when politicians create policies with loopholes that mean they will not have the same benefits that others do. These loopholes affect some who are poor and some who work for religious institutions. This is not weaving the marginalized into the social fabric of opportunities and services we all enjoy. Instead, it ensnares policymakers in the illusion that they must sell out some Americans to benefit others.

Catholics believe that everyone, without exception, deserves the freedom to follow their conscience. Effective family planning and equitable public health policy require a similar commitment to all individuals' moral decision making about contraception—not a patchwork of promises that benefit only some Americans.

Reference

[1] Coleman D, Jones KP. Title X: a proud past, an uncertain future. Contraception 2011;84:209–11.

Comment on: Li HW, Wong CY, Yeung WS, Ho PC, Ng EH. Serum anti-Mullerian hormone level is not altered in women using hormonal contraceptives. *Contraception* 2011;83:582–5

To the Editor:

Anti-Müllerian hormone (AMH) can serve as a valuable marker to assess ovarian reserve status or predict age at menopause in normo-ovulatory women [1]. The issue of measuring AMH may also be of relevance for women using hormonal contraceptives. Therefore, the recent publication by Li et al. [2] on AMH levels in women using several types of hormonal contraceptives can be considered a valuable addition to the sparse literature on this topic. However, we are concerned that the study design used as well as the type of data analyses performed may have distorted the study's conclusions.

The results of the study showed no significant differences between pre- and posttreatment AMH concentrations in the different treatment groups (i.e., different types of hormonal contraceptives). Unfortunately, the corresponding p values were not reported. Moreover, the fact that the rather large difference between pre- and posttreatment AMH concentrations of the group using combined oral contraceptives (27.2 and 17.1 pmol/L, respectively) did not reach statistical significance suggests this study might have suffered from a lack of power. The authors themselves argue that the large pre- and posttreatment differences found can be explained by the large heterogeneity of their subjects. However, detailed information regarding this heterogeneity is lacking, making it difficult to verify this statement.

The measurements during the natural menstrual cycle as well as during hormonal contraceptive use were not timed. The authors considered this not to have a major effect on their results since it has been demonstrated that AMH concentrations are rather stable throughout the menstrual cycle. However, other studies are available that found the opposite [3]. In addition, no data are available on day-to-day fluctuations of AMH during hormonal contraceptive usage, nor on the effect of duration of this usage. As a consequence, the fact that the timing of the measurements was not standardized might have had a considerable effect on the results found.

Finally, the authors conclude that their results are "in line with previous reports showing that combined hormonal contraceptives did not affect serum AMH concentration". However, the authors fail to mention that other reports indicating that AMH levels seem to decrease during oral contraceptive use [4] and to increase during the hormone-free interval [5] are available as well.

All in all, the conclusion of Li et al. [2] stating that AMH is a useful clinical test in hormonal contraceptive users for the differential diagnosis of anovulatory disorders and the determination of menopause in our opinion is somewhat impetuous and needs to be further established by future research.

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References

[1] Broer SL, Eijkemans MJ, Scheffer GJ, et al. Anti-mullerian hormone predicts menopause: a long-term follow-up study in normoovulatory women. J Clin Endocrinol Metab 2011;96:2532–9.

[2] Li HW, Wong CY, Yeung WS, Ho PC, Ng EH. Serum anti-mullerian hormone level is not altered in women using hormonal contraceptives. Contraception 2011;83:582–5.

[3] Sowers M, McConnell D, Gast K, et al. Anti-Mullerian hormone and inhibin B variability during normal menstrual cycles. Fertil Steril 2010; 94:1482–6.

[4] Arbo E, Vetori DV, Jimenez MF, Freitas FM, Lemos N, Cunha-Filho JS. Serum anti-mullerian hormone levels and follicular cohort characteristics after pituitary suppression in the late luteal phase with oral contraceptive pills. Hum Reprod 2007;22:3192–6.

[5] van den Berg MH, van Dulmen-den Broeder E, Overbeek A, et al. Comparison of ovarian function markers in users of hormonal contraceptives during the hormone-free interval and subsequent natural early follicular phases. Hum Reprod 2010;25:1520–7.

Response to letter to the editor: Serum anti-Mullerian hormone level is not altered in women using hormonal contraceptives

To the Editor:

We thank van den Berg et al. for their interest in our paper and their constructive comments.

We demonstrated no overall significant difference between pre- and post-treatment anti-Mullerian hormone (AMH) concentrations in the different treatment groups, with a p value of >.05 in all treatment groups. We have illustrated the large interquartile range of baseline AMH concentrations among subjects both within and between the treatment groups. The median (interquartile range) ΔAMH (i.e., post-treatment AMH minus pretreatment AMH) in the five treatment groups is shown in Table 1.

We noted the apparently conflicting reports in the literature about the intra- and inter-cycle variability of serum AMH concentration in users of combined oral contraceptives (COC) [1−3] and in natural menstrual cycles [4,5]. Sowers et al. [5] reported more significant fluctuations in women who had higher baseline AMH levels. However, in this selected group of subjects, their baseline AMH level was distinctly high and such further fluctuations would unlikely affect its clinical meaning.

We are aware of reports which suggested that AMH levels seem to decrease during COC use [2] and to rise during the hormone-free interval [3]. However, in the study by Arbo et

Table 1
Change in serum AMH concentration, ΔAMH (post-treatment minus pretreatment levels), in subjects using hormonal contraception

Group	Median ΔAMH	Interquartile range
Combined oral contraceptive	−1.69	−23.39 to +4.67
Combined injectable contraceptive	+0.53	−13.41 to +9.36
Progestogen-only pill	−0.28	−0.87 to +3.12
Progestogen-only injectable	−0.87	−3.91 to +3.64
Levonorgestrel intrauterine system	+0.49	−4.17 to +3.04