Author’s response to reviews

Title: Real-world experience of women using extended-cycle vs monthly-cycle combined oral contraception in the United States: the National Health and Wellness Survey

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Author’s response to reviews:

Dr. Santiago Palacios
Associate Editor
BMC Women’s Health

Dear Dr. Palacios:

Thank you for your and the reviewers’ comments on our paper titled, “Real-world experience of women using extended-cycle vs monthly-cycle combined oral contraception in the United States: the National Health and Wellness Survey,” submitted to BMC Women's Health (BMWH-D-17-00225). We have detailed our responses to each comment below, and we note the manuscript pages where revised text can be found.

We look forward to receiving your comments on the revision. Please do not hesitate to contact me by phone and/or email if there is any other information that you require.

Sincerely,

Rossella E. Nappi, MD, PhD
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Reviewer 1 Comments:

It is very interesting, well developed and with clear conclusions. My comments are:

1. I do not understand why the Hispanic female population is so low in the study, when in the United States alone, the Hispanic population is 11.7% of the entire population.

Response: The US National Health and Wellness Survey (NHWS) uses a stratified random sample method that includes gender, age, and ethnicity strata in an effort to ensure the demographic composition of the sample is similar to the corresponding adult US population. Within the 2013 US NHWS, the women who were eligible for inclusion in our study were currently using either monthly-cycle or extended-cycle combined oral contraception. In these groups of women, Hispanic ethnicity was reported by 8.2% and 6.5% of women, respectively, which, as noted by the reviewer, is lower than the proportion of the general US population who report Hispanic ethnicity. Not reported in our study is the group of women who met our age inclusion criteria but were excluded because they were not currently using combined oral contraception (N=11,464). In this group of women, 12.8% reported Hispanic ethnicity. Thus, it appears that the US NHWS included a representative proportion of Hispanic women, but relatively fewer of these women were current users of combined oral contraception. Unfortunately, we do not know the reasons underlying why individual women were not currently using combined oral contraception, which could include desire for pregnancy, lack of access to prescription birth control, dissatisfaction with a prior experience using combined oral contraception, or cultural attitudes toward hormonal birth control or bleeding preferences.

2. The clear criticism of the study is that it compares a population of 260 versus 3,616, as they point out.

Response: We have added the smaller sample of women reporting extended-cycle versus monthly-cycle COC to the study limitations on page 14. We also note on page 14 that the small percentage of women reporting current use of extended-cycle COC indicates that there is a continued need for improved awareness of the availability and utility of extended-cycle COC.

Reviewer 2 Comments:
I reviewed the Manuscript titled “Real-world experience of women using extended-cycle vs monthly-cycle combined oral contraception in the United States: the National Health and Wellness Survey” (BMWH-D-17-00225). The study compares data of women used extended cycle combined oral contraception versus traditional 21/7 combined oral contraception with the purpose to evaluate therapy satisfaction, adherence and menstrual cycle symptoms. The analyzed data refers to a large cohort of women (aged 18-50) enrolled. I really appreciated the Manuscript topic and I think that the study should be very helpful to guide the clinicians in contraceptive management. However, it would be interesting to deep into several elements that could strongly improve the study validity as suggested in my review.

The manuscript may benefit from some revisions, as suggested below:

1. Materials and Methods: Inclusion and exclusion criteria are not clear. For example, comorbidities that may affect women before starting the oral contraception treatment are not reported. In this view, it becomes necessary specify which estroprogestinic drug and which dosage are used in the treatment and if the therapy solve manifestations.

Response: We have revised the Methods to more clearly state the study inclusion criteria on page 6. Eligible women met the inclusion criteria of 18 to 50 years old, premenopausal, without hysterectomy, and self-reported current use of combined oral contraception. We did not exclude women based on comorbid disease. We examined comorbid disease burden using the Charlson Comorbidity Index and found no significant difference between women using extended-cycle vs monthly-cycle COC, as reported on pages 7 and 9. We also examined several diagnosed comorbid diseases and report on page 10 the significant differences between groups in diagnosed migraines, headaches, sleep difficulties, heartburn, hypertension, and irritable bowel syndrome. Due to space limitations, we do not report the diagnosed comorbid illnesses that were not significantly different between groups, but these included anxiety, social anxiety disorder, generalized anxiety disorder, depression, insomnia, high cholesterol, asthma, nasal allergies, urinary tract infection, eczema, yeast infection, thyroid condition, anemia, and arthritis. Our predefined study scope did not include comparisons among specific COC formulations and estroprogestinic doses used by women are not available within the National Health and Wellness Survey. We note these as study limitations on page 14. We are not able to address change in comorbid illness because this study is cross-sectional. This limitation is noted on page 14.

2. Materials and Methods: The validity of the study should be significantly improved by the analysis of the sexual grade of satisfaction. We think that it represents an important element that could really impact the quality of daily life. In our opinion, thus, sexual grade of satisfaction deserves a deep evaluation during the cycle combined oral contraception. Moreover, also for this aspect, it should be auspicial to clarify which estroprogestinic and which dosage are used in the treatment to have a better acknowledgment of the outcomes (1-2). Did both regimens contain the same quality and quantity of estrogen and progestogen? This information could be interesting for the reader.
Response: We thank the reviewer for pointing out the need for greater emphasis in this important area. We agree that greater examination of sexual satisfaction among contraception regimens is needed. We have added a statement, along with the first suggested reference above, to the Discussion on page 13 that further study of the potential benefit of extended-cycle regimens on sexual behavior and satisfaction is needed (please note that we did not include the second reference above as we felt the 24/4 extended-cycle regimen was too dissimilar to our focus on extended-cycle COC with 3 months between periods). Unfortunately, outcomes related to sexual behavior and satisfaction were not included in the NHWS measures, and as noted above, we do not have information about the estrogen and progestogen doses used by the women in our study (included as a study limitation on page 14).