

cefixime were compared with those of IV aminoglycoside therapy for the empirical treatment of UTI, judged by the investigator to require initial therapy with a parenteral antimicrobial agent. The study design was consistent with standard clinical practice. After 2-3 full days of parenteral study therapy, investigators had the option to switch to oral cefixime if the patient had clinically improved. Results of this study show that ceftriaxone with switch to cefixime, 8 mg/kg once a day, was highly effective and equivalent to treatment with IV aminoglycoside therapy. Approximately 88% of patients in treatment group B (treated with switch therapy) had a favorable clinical/microbiologic response assessment at the 7 days post therapy. Although rate of response (clinically and microbiologically) to children of group B, who received ceftriaxone with switch to cefixime, was higher than children treated with IV aminoglycoside (88 versus 80%), there was no statistical significant difference between the rate of response in 2 groups ($p=0.82$). Although we did not measure psychological, aspects of mother's support during oral therapy at home compared to IV therapy in the hospital, we suggest that oral therapy at home associated with a mother's psychological support could be considered a positive aspect of switch therapy. Switch therapy with cefixime in children with UTIs increases effectiveness and convenience. Switch therapy shortens duration of hospitalization, and decreases costs and risk of nosocomial infections. Cefixime could also be considered as switch therapy in children with UTIs.

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The services provided for combined oral contraceptive users in health care centers, Kerman, Iran

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Combined oral contraceptives (OC) are the most effective reversible form of contraception available. They have also several health benefits on genital system, breast, bones, and others.¹ Some misconceptions regarding the safety of these compounds and also insufficient knowledge regarding their beneficial effects cause irregular use or stopping and consequently the occurrence of unwanted pregnancies. Therefore, physicians and other health care providers should consult their patients regarding safety of these compounds and urge them to take their pills regularly. As the main reason for stopping oral contraceptives is fear of their probable side effects, regular visit and consultation may help the continuity of using OC.² Mentioning of health benefits in each visit is necessary. Moreover, taking a complete history, blood pressure and weight measurements, breast, liver and pelvic physical examination and doing Pap smear for early diagnosis of probable problems are necessary. In this descriptive cross-sectional study, the rate of services provided for the combined OC users in the health care centers of Kerman City was evaluated. Sample size was determined in 600 women. Subjects were selected randomly from 33 health care centers. Receiving of OC pills from health centers at least for one year prior to the study was criteria inclusion. Subjects were questioned regarding the control of blood pressure and weight measuring, the examination of breast, liver and pelvis or recommendation for that and Pap smear carried out during the recent year. It should be mentioned that in regard to the physical examination of breast, liver and pelvis, in centers having educated midwives the rate of performed examinations and in centers lacking midwives the rate of recommendations were considered. Data were collected by interviewing subjects and were analyzed by descriptive statistical methods. In order to study the services provided for the combined OC users, 6 factors based on the health center facilities were considered. Blood pressure measuring had been carried out in 500 subjects (83.3%), weight measuring in 506 (84.6%), examination of breasts or recommendation to carry out in 322 (53.7%), pelvis in 120 (20%), liver in 6 (1%) and finally Pap smear that is one of the main responsibilities of these centers and had been performed in only 246 ones

(41%). Oral contraceptives are one of the most effective methods of contraception used around the world. Contraceptive use data from 1965-1995 shows that OC continue to be the method chosen consistently by more than one-quarter of women contraceptors. Probably even more women would use the pill if they had more accurate information regarding the higher failure rate with barrier method, if misconceptions regarding OC safety put to rest and if greater awareness of the noncontraceptive health benefits of OC could be achieved. Increased education and awareness of women as well as their health care providers has the potential to positively affect future contraceptive use.³ In addition to clinical benefits of the OC, which outweigh the risks and adverse effects, these compounds cause some metabolic changes in body such as change in lipids, lipoproteins and carbohydrate metabolisms. In healthy women with no high risk factor, these metabolic changes are trivial and have no risk. Oral contraceptives may increase the risk of breast, cervix and liver cancer. They can also have some cardiovascular effects such as arterial thrombosis, cerebral stroke, hypertension and myocardial infarction. Cardiac and cerebral diseases that are the most serious effects are observed mostly in smoking women aged more than 35. Risk of mortality from OC is very low in non-smoking women, younger than 35 who have no systemic disease and it is definitely less than the risk of mortality due to pregnancy.¹ There is little evidence to suggest any persistent adverse effect 10 or more years after use of OC and mortality in past users is similar to that nonusers. In order to increase the safety of OC at least yearly follow-up is necessary. A sufficient follow up depends on the knowledge of both users and health care providers regarding the side effects of these compounds. Brayden and Fletcher⁴ showed that knowledge concerning the health risks and benefits of OC use is a contributor to OC compliance and the number of correct responses to questionnaire increased with academic year, indicating that younger women were less knowledgeable regarding OC. The results of this study indicate that despite increased efforts to educate women, knowledge of OC remains a major problem even in a sample of women with relatively high socio-economic status. Poor knowledge regarding the benefits and side effects of OC is the main contributing factor to pill failures and to approximately 20% unwanted pregnancies.⁵

Knowledge in contraception is important for avoiding pregnancy and yet very few know the basic rules for it. Health professionals should provide leaflets and ask questions on knowledge of contraception at consultations for repeat prescriptions of the contraceptive pills, as education seems to improve knowledge of contraception even after one consultation. Therefore, The ideal time for consulting users and detecting the probable side effects is at the time of users referring for follow up and receiving their pills. Preparation of educational leaflets containing the health benefits, side effects and schedule of pill taking can be very useful.⁵ In developing countries, a lack of appropriate family planning information and services is more of an immediate obstacle to increased use of contraceptives than is low demand. Based on the results of the present study follow up of OC users in Kerman City is not good. Training of health care providers and OC users in relation to this effective contraceptive method will have useful potential effects and consequently will lead to the better OC compliance and use of these compounds consistently.

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