

from the market for safety reasons.³ Moreover, this ratio has increased to one-third for drugs given a priority review. Because we do have specific evidence for interactions between some medications and grapefruit, the public should be updated about new drugs where this interaction may be missed.

Is it sufficient that we identify these warnings and withdrawals only after they may have caused human suffering? After 20 years and hundreds of research publications on the topic of grapefruit–drug interaction, is there not enough well-documented science to predict with high likelihood the adverse effects and toxicity before unnecessary exposure? Our considered contention is that this is indeed the case. Moreover, a recent editorial in *BMJ* has lent further credence to the relevance of our conclusions.⁴

Even if the incidence of serious toxicity from a grapefruit–drug interaction was low in the patient population, which is as yet not fully known, the consequences would be dire (yet easily prevented). Moreover, why would you knowingly or even theoretically put yourself or others in harm's way? Caution is by far the wisest approach.

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CMAJ 2013. DOI:10.1503/cmaj.113-2110

Pregnancy and isotretinoin therapy

We read with interest the article by Choi and colleagues on isotretinoin therapy and the importance of a multi-level approach to ensure adequate contraception in women taking potentially teratogenic medications.¹ We agree that it is essential that health care providers know the failure rates of various contraceptive methods when counselling

patients. However, we encourage health care providers to become familiar with the more recent and accepted perfect and typical use failure rates reported by Trussell and colleagues in Appendix 1, available at www.cmaj.ca/lookup/suppl/doi:10.1503/cmaj.1132111/-/DC1,² which in some instances are quite different than the ones cited by Choi and colleagues.³

The rates reported by Trussell and colleagues are referred to in numerous contraception guidelines including those from the Society of Obstetricians and Gynaecologists of Canada,⁴ the Centers for Disease Control and Prevention,⁵ and the World Health Organization.⁶

Prescribers must also understand the difference between perfect-use and typical-use failure rates. Failure rates are reported as the percentage of women who will have an unintended pregnancy during the first year of use of a method. Perfect use may be hard to achieve, particularly with more compliance-demanding methods, which explains why typical-use failure rates are much higher than perfect-use failure rates with methods such as condoms and oral contraceptives. Long-acting reversible contraceptive methods such as intrauterine contraceptive devices and implants are not as reliant on user compliance and hence typical-use failure rates approach those of perfect-use rates. Long-acting reversible contraceptives also have lower discontinuation rates at one year.²

We encourage contraceptive prescribers to be familiar with Trussell's reported failure rates,² and reiterate that women of reproductive age who use teratogenic medications should be counselled about all contraceptive options — particularly long-acting reversible contraceptives given their low typical- and perfect-use failure rates and their increased adherence.

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CMAJ 2013. DOI:10.1503/cmaj.113-2111

The authors respond

We thank Dumont and Black¹ for further raising the issue of the need for effective contraception in order to prevent pregnancies during isotretinoin treatment.

Our report² included only the typical-use contraception failure rates. Please note that Box 1 in our manuscript provides the same typical-use failure rates as reported by Trussell and colleagues and quoted by Dumont and Black.²

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CMAJ 2013. DOI:10.1503/cmaj.113-2112

Letters to the editor

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