LETTERS

Anti-D guidelines

Madam,

We read with interest the letter on 'GP use of anti-D' published in April 2000[1] and would like to draw attention to the recent changes in the guidelines for the administration of anti-D in early pregnancy as recommended by the British Transfusion Society and the Royal College of Obstetricians and Gynaecologists.

The following points are relevant:

1. Anti-D must be given to all RhD negative women having therapeutic termination of pregnancy, whether by surgical or medical methods, regardless of gestational age, unless they are known from blood tests to already have immune anti-D.
2. Anti-D must be given to all non-immunised RhD negative women who have an ectopic pregnancy, irrespective of gestational age.
3. Anti-D must be given to all non-immunised RhD negative women who have a spontaneous complete or incomplete abortion after 12 weeks of pregnancy.
4. Anti-D should be given when there has been instrumental intervention to evacuate the uterus. Spontaneous complete miscarriage before 12 weeks does not require any anti-D, as significant fetomaternal haemorrhage does not occur.
5. Routine administration of anti-D is not recommended in threatened miscarriage with viable pregnancy. However, it may be prudent to administer anti-D where bleeding is heavy or repeated, or where there is associated abdominal pain specifically as gestation approaches 12 weeks. When bleeding continues intermittently after 12 weeks gestation, anti-D should be given at 6-weekly intervals. The gestational age should be confirmed by ultrasound.

Full guidelines are available from the College or can be downloaded from the website: http://www.rcog.org.uk/guidelines/antid.html.

These guidelines represent evidence-based practice. Based on these guidelines, women in the community or in hospital who have a spontaneous miscarriage without therapeutic intervention, or threatened miscarriage prior to 12 weeks, do not need anti-D. Therefore the reported 7-11% of the RhD negative women who were cared for in the hospital have received adequate care.

Kanchan Kanjilal
Specialist Registrar

Margaret Tasker
Consultant
Department of Obstetrics and Gynaecology, Royal Bolton Hospital, Bolton, Lancs, BL4 0JR, UK

Reference
1 Goulding C, Hamilton W. GP use of anti-D. *Br J Fam Plann* 2000; **26 (2)**: 116.

FP provision in GUM clinics

Madam,

In their article,[1] Bardsley et al discussed contraception services provided by family planning clinics and GPs in London. They failed, however, to consider the role of the genitourinary medicine (GUM) departments. A review[2] of family planning and contraception services, offered by local GUM clinics, was undertaken as part of North and South Thames Regional GUM audit in August 1996. A survey of 31 units in North Thames and 33 units in South Thames was conducted. Thirty-seven units returned completed questionnaires giving a 58% response rate. Over 70% of responding units (n = 27) provided contraception with one third (n = 12) offering specific family planning sessions. One quarter of responding units (n = 9) had a designated family planning doctor with 50% (n = 19) employing a family planning nurse. Both the Yuzpe (31 units; 84%) and the progestogen-only (12 units; 32%) hormonal contraception methods were offered. In addition, eight units (22%) offered emergency intra-uterine device contraception.

Despite survey limitations, including participation rate and self-reporting bias, these results suggest that family planning and emergency contraception provision within GUM is considerable. There are a number of benefits of providing such a service. Walk-in clinics offer convenient access to specialist advice without appointment. This may appeal to younger clients. Screening for sexually transmitted infections, partner notification and health promotion can be provided within an integrated service.

Indirect evidence from KC 60 statistical returns shows that increasing numbers of women are accessing GUM departments, with a 19% increase in family planning provision between 1997 and 1998.[3] Furthermore, all specialist registrars in GUM are required to obtain the Diploma of the Faculty of Family Planning (DFFP) as an essential training requirement. The advantages of providing family planning/ contraception in association with GUM services have been recognised[4,5] and form part of the Sexual Health Strategy currently under discussion.

Acknowledgement
We should like to acknowledge all those who contributed to the Regional GUM Audit process in the North and South Thames regions.

Greta Forster, FRCOG, MFFP
Consultant in GUM, Royal London Hospital, London, UK

Adam Dale, BSc
RN Regional Audit Co-ordinator, GUM, HIV and AIDS, Clinical Governance Support Unit, St Pancras Hospital, London, UK

Gary Brook, FRCP
Consultant GU Physician, Central Middlesex Hospital, Middlesex, UK

David Daniels, FRCP
Consultant GU Physician, West Middlesex Hospital, Middlesex, UK.

David Tomlinson, FRCP
Consultant GU Physician, St Mary's Hospital, London, UK

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2 North and South Thames Regional Audit: Family planning and emergency contraception. http://www.nthivgumaudit.demon.co.uk/ int/fampln.htm
3 Lamagni TL, Hughes G, Rogers P, et al. New cases seen at genitourinary medicine clinics: England 1998. *Commun Dis Rep CDR Suppl* 1999; **9 (Suppl. 6)**.
4 Masters L. Nicholas H, Bunting P, et al. Family planning in genitourinary medicine: an opportunistic service? *Genitourin Med* 1995; **71**: 103–105.
5 Carlin EM, Russell JM, Sibley K, et al. Evaluating a designated family planning clinic within a genitourinary medicine clinic. *Gentiourin Med* 1995; **71**: 106–108.

The Nova T series of IUDs

Madam,

Following the review article on IUDs in the January 2000 edition of the *BJFP*,[1] the question arises as to whether family planning services should abandon the Nova T200 for the Nova T380, and whether they should advise their local GPs and PCGs to do the same. I believe that this needs some consideration, as the Nova T380 is over twice the price of the older version and is not reimbursable on the NHS for GPs.

The chief use of the Nova T series is in women with a narrow cervical canal, as the inserter tube is slimmer than that of the Gyne T380 or the Multiload. Many of these will be young nullips needing a post-coital IUD, which will be removed at the next period. As the failure rate of post-coital IUDs is no higher than 0.1 %,[2] is there any evidence that the Nova T200 is less effective than the 380 in this situation?

The published evidence on the superior effectiveness of the Nova T380 only extends to 2 years of follow-up on 259 women.[3] Further work is in progress through the UK family planning network. Should we wait for this evidence before making a decision for our services at a time when budgets are under pressure and clinics all over the UK are threatened with closure?

Lesley Bacon, MFFP, MRCGP
Consultant in Family Planning, Community Health South London NHS Trust, London, SE5 7RN

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2 Faculty of Family Planning and Reproductive Healthcare. Interim guidance October 1999, recommendation for clinical practice – emergency contraception.
3 Batar, Kuukankorpi, Rauramo, et al. Two year clinical experience with Nova T380, a novel copper-silver IUD. *Advances in Contraception* 1999; **15**: 37–48.

Fees for DFFP practical training sessions

Madam,

For several years now the training clinics in Devon and Cornwall have charged £20.00 per session for the practical sessions for the DFFP. Up until now there has been no problem with this, but this year the trainees on the Plymouth VTS training scheme have started to complain about having to pay for their practical training sessions in our clinics. Apparently they are not able to claim for these fees from the postgraduate training budget.

I would very much like to know if other services charge for the practical training sessions and, if so, how much.

Yvonne Pollitt, MB BS, MFFP
Medical Lead, Plymouth Community Services NHS Trust, S.A.F.E. (Sexual Health Advice for Everyone), Cumberland Centre, Damerel Close, Devonport, Plymouth, PL1 4JZ.

Training fees and DFFP: Reply

Madam,

Support for training is available and is administered in different ways throughout the UK. The training budget allocation supports all vocational education training. This budget has been devolved and is administered regionally by postgraduate deans. It is a cash limited budget and will be used locally to support a variety of activities within a training remit, including courses for trainees, half day release for trainees, travel and subsistence and support for training the trainers.

DFFP has a theoretical and practical component. GP vocational trainees should get the fees for the theoretical course and practical training reimbursed through the vocational training budget. It is possible for trainees to gain part of the practical experience within a general practice setting. The DFFP logbook should facilitate this where it is locally relevant to the training process. Sessions attended in community settings are usually charged for (unless there is a reciprocal exchange of trainees with another department which has been previously negotiated) and should be reimbursable. The basis for funding for many community services is for delivery of clinical services and does not recognise a training component. In order to balance service and training commitments, most services charge for practical training sessions. This is in the order of £20-25, which is roughly the additional salary cost to upgrade a CMO session to that of instructing doctor.

In hospital settings there is often a cash limited sum allocated to each SHO for training which they can prioritise for DFFP. This cash limit is in excess of the sum normally charged for complete DFFP training.

At a local level you need to enter into negotiation with the gatekeeper of the money - the postgraduate dean - and enlist the help of your regional advisor.

Urszula Bankowska
Chair of the General Training Committee, Faculty of Family Planning and Reproductive Health Care

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