Letters to the Editor

Full-term pregnancy with Implanon® *in situ*

An 18-year-old nulliparous woman who had had no bleeding since the insertion of an etonogestrel subdermal contraceptive implant (Implanon®) 4 months earlier had a positive pregnancy test. The implant was easily palpable and correctly sited. An ultrasound scan showed the gestation was 27±2 weeks.

Review of the patient's general practitioner (GP) records indicated that the Implanon had been inadvertently inserted when she was already pregnant. She had not regained regular menstruation since stopping depot medroxyprogesterone acetate contraceptive injections (Depo-Provera®) 6 months previously and switching to condoms. At the time of fitting she denied any sexual intercourse since splitting up with her boyfriend 6 weeks previously. She had had two negative pregnancy tests, one on the day of fitting.

Her GP (H.P.) referred her to a specialist contraception clinic for removal of the implant, where she attended 3 weeks after the pregnancy diagnosis (now 30 weeks' gestation). The patient said she was happy with the implant and would wish to use it again after delivery, and she asked if it had to be removed. The doctor in the clinic (H.C.) discussed with the patient the lack of evidence about the correct course of action, and explained that progestogens in pregnancy have not been linked with fetal abnormality. In addition, it was unlikely that the rate of progestogen release from the implant would be altered in pregnancy and there was no reason to expect the low blood levels of progestogen to interfere with labour or delivery. Use of Implanon during lactation is standard (although the patient planned to bottle-feed). Keeping the implant in place therefore seemed to be an option.

The GP informed the manufacturers of Implanon (Organon), who of course recommended removal. After discussion it was agreed that it was reasonable for the implant to be left in place, giving the patient the opportunity to return if she changed her mind and decided she wanted it removed. Informal discussion with a few colleagues indicated the majority would advise removal but could not give any clear reason why.

The patient had a spontaneous labour and normal delivery of a healthy baby girl weighing 3.3 kg at 40+2 weeks' gestation. At routine follow-up at 6 weeks the baby was being bottle-fed and showed no signs of abnormality. The mother was healthy and the implant still had nearly 2.5 years of its licensed life left.

What would other readers have advised in this situation?

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The patient gave her consent to the publication of this report.

Chlamydia rates in postcoital IUD recipients

Swab results were checked for 105 recipients of a postcoital intrauterine device (IUD) in Sheffield, UK in 2004. Only one chlamydia result was positive.

A computer-generated list was used to identify all recipients of a postcoital IUD in Central Health Clinic, Sheffield in 2004. Paper notes were then obtained and checked. The age range of recipients was 13–52 years; 54 were aged under 25 years. All received pre-IUD counselling, including discussion regarding infection/sexually transmitted infections (STIs). All recipients were recorded as having had endocervical swabs for gonorrhoea and chlamydia. Results were checked both on computer and in the notes. One client was excluded because of recent antibiotics (within 2 weeks of the swabs). One set of results could not be found. One result was positive for chlamydia and 102 results were negative.

One positive chlamydia result was less than the figure expected from local and national prevalence figures of 3–12%.[1,2]

Risk of infection can be discussed in the consultation to exclude those who are symptomatic for pelvic inflammatory disease or at high risk of acquiring an STI. We believe pre-IUD counselling helps clients most at risk of chlamydial infection to choose not to have an IUD fitted, even if the patient withholds relevant information (the informed user being a sensible user). A prospective study of all clients considering a postcoital IUD would be valuable to explore this impression further.

Our study supports research findings that prophylactic antibiotics are not cost effective.[3]

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Mirena® IUS and ovarian function

"Accurate, up-to date information is essential to enable users to make an informed and voluntary choice of contraceptive method", declared the National Institute for Health and Clinical Excellence (NICE) guidelines,[1] which also stated that "User satisfaction and successful use of contraception depend on adequate knowledge and accurate perceptions of the method".

At present there is strong evidence that the frequency of functional ovarian cysts is increased in the presence of the levonorgestrel-releasing intrauterine system (LNG-IUS). Some of the studies showed that as many as 30% of women identified ovarian cysts 3 months after LNG-IUS insertion.[2] According to the NICE guidelines, "The incomplete suppression of ovarian activity in LNG-IUS users is a recipe not only for erratic bleeding, but also for the development of ovarian follicular cysts".[1] As stated in the Summary of Product Characteristics for the Mirena® IUS, functional ovarian cysts have been diagnosed in about 10–12% of patients.[3] In most cases they are small and asymptomatic, and disappear spontaneously.

The FFPRHC Guidance published in April 2004[4] stated that: "Women may be reassured that although ovarian cysts occur in LNG-IUS users, there is no significant increased risk compared to IUD users". The NICE guidelines published in October 20051 asserted that: "Development of ovarian follicular cysts … occurs in 20% of women using the LNG-IUS". But according to these NICE guidelines there is no need to inform patients about this risk prior to IUS insertion.

"The LNG-IUS is a suitable option for most women who need contraception and/or treatment for menorrhagia" stated the FFPRHC Guidance.[4] According to the NICE guidelines, the IUS is becoming one of the most cost effective, close to an ideal contraceptive device with high efficacy, ease of use and almost no absolute contraindications (except current malignancies or genital/pelvic infection). "The IUS may be used by adolescents … nulliparous women …women of all ages may use the IUS".[1] It is likely that the frequency of IUS use will significantly increase from its current level (1%).[1] Indeed, our service is actively promoting long-acting reversible contraception and the IUS in particular.

Future IUS users are more likely to have no menstrual or pelvic pain problems prior to IUS insertion and they are highly likely to develop them later, which will have an important impact on the IUS discontinuation rate and the overall cost effectiveness. At present, up to 60% of women will stop using the IUS within 5 years. The most common reasons for discontinuation are unacceptable vaginal bleeding and pain.[1]

Cost effectiveness and utility for the patient are also affected by the way IUS-induced ovarian cysts are investigated. Functional ovarian cysts are infrequent in women not using hormonal contraception or in women on combined oral contraception.[5,6] Currently, the typical IUS user is over 30 years old. Westhof and Clark found that women aged 30–34 years had the highest rate of admission for functional cysts: 142/100 000 woman-years.[7]

While there are Royal College of Obstetricians and Gynaecologists (RCOG) guidelines for the management of ovarian cysts in postmenopausal women,[8] there is currently no nationally agreed algorithm for the management of ovarian cysts in premenopausal women.

There is also no absolute opinion on the place of routine ultrasound investigations for LNG-IUS users: some studies recommend it and some do not, as ovarian cysts have a high rate of spontaneous resolution.[5] It is, for example, unclear how long one should wait for resolution of the cyst, when the scan should be performed and how frequently it is to be repeated. This was not an issue in the past when IUS use was infrequent. The new generation of IUS users may not be prepared to cope with functional ovarian cysts. The likelihood of increased IUS use will make the development of algorithms for the management of functional ovarian cysts and/or pelvic pain a high priority. As Sturridge and Guillebaud declared in 1996, "the unique unwanted non-contraceptive effects of the system, including possible development of functional ovarian cysts, and the relationship between menstrual bleeding pattern and ovarian function, also require better understanding, in order to offer appropriate patient counselling and maximise acceptability and continuation of use of the method".[9] Although this statement was originally made in 1996, it is even more appropriate for 2006.

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