Ovarian cancer and oral contraceptives: collaborative reanalysis of data from 45 epidemiological studies including 23 257 women with ovarian cancer and 87 303 controls. Collaborative Group on Epidemiological Studies of Ovarian Cancer, Beral V, Doll R, Hermon C, Peto R, Reeves G. *Lancet* 2008; **371**: 303–314

This is another of the large meta-analyses regularly produced by this group of researchers. This time they have looked at ovarian cancer risk and the combined oral contraceptive pill (COC), and confirmed that the COC greatly reduces the risk. The risk decreased by 20% with every 5 years of COC use, and for women who took the pill for 15 years, the risk was halved. The duration of protection lasted for many years after stopping the pill; even after 30 years there was still a significant reduction in risk [relative risk (RR) 0.86, 95% CI 0.76–0.97]. Between 10 and 19 years after stopping, the RR was 0.67 (95% CI 0.62–0.73), namely a roughly 40% reduction in risk. Importantly, the authors conclude that the protective effect is similar for both high- and low-estrogen dose pills. They estimate that around 200 000 ovarian cancers have already been prevented by COC use in the last 50 years and predict that around 30 000 cases of ovarian cancer per year will be prevented in future. Two accompanying editorials both suggest that the pill should be made available over the counter, though without any suggestions of how this should be done in practice to maintain patient safety.

Reviewed by **Anne Szarewski,** PhD, FFSRH
Clinical Consultant and Honorary Senior Lecturer, Cancer Research UK Centre for Epidemiology, Mathematics and Statistics, Wolfson Institute of Preventive Medicine, London, UK

LETTERS TO THE EDITOR

Difficult insertion of IUS

We were relieved to read the letter[1] about difficult insertion of the intrauterine system (IUS) in the October 2007 issue of the Journal because we and at least one other colleague have had exactly the same experience.

I (MD) have been fitting intrauterine devices (IUDs) for over 35 years and have had six or seven of these in the last year, each needing another IUS or indeed another IUD usually the TT380 Slimline®. I fit on average 40 IUDs per year.

A colleague, who is also a general practitioner, with more than 5 years' experience, fits on average 20 per year. She has come across this problem twice, one episode requiring opening a third IUS to get it fitted, thus believing it must have been her own error (despite fitting it in the same way as always).

Finally, a locum doctor, of many years experience as myself, had one.

I have retained two of these devices, whose batch numbers are different.

We are now concerned that there is something wrong with the technique so that there may also be devices not correctly placed at the fundus.

The fitting of the TT380 Slimline differs entirely as the plunger is held at the base of the IUD before removing the insertion tube so we have never had a problem with it.

Jeanette Ledbury, FFSRH
Clinical Medical Officer, Saltergate Contraception and Sexual Health, Saltergate Health Centre, Chesterfield, UK

Margaret Duncan, MRCGP, DFSRH
General Practitioner and Staff Grade Doctor, Saltergate Contraception and Sexual Health, Saltergate Health Centre, Chesterfield, UK.
E-mail: margoduncan@mac.com

Reference
1 Albertazzi P. Difficult insertion of IUS [Letter]. *J Fam Plann Reprod Health* Care 2007; **33**: 287.

Reply

With reference to the letter to the editor by Dr Albertazzi[1] describing a case of difficult insertion of an intrauterine system (IUS), and the follow-up letter by Drs Ledbury and Duncan,[2] we would like to take the opportunity to respond to these letters.

Bayer Schering Pharma considers customer feedback to be an extremely valuable tool in continuing to develop products that deliver the highest levels of customer satisfaction as well as to ensure their safe use. Spontaneous feedback is particularly important in order to make us aware of potential problems, enabling us to deal with them in a prompt and appropriate manner.

To enable thorough evaluation of individual cases, it is important that all available material (in the case of IUSs, the IUS with threads, the inserter and the outer package containing the batch number) together with a description of the difficulty encountered is forwarded for investigation. Details of how this can be arranged should be discussed with the local subsidiary of the company.

In the case described by Dr Albertazzi,[1] a quality defect could be suspected, based on the failure of the IUS to deploy after two consecutive attempts. An attempt with a new IUS and inserter was subsequently successful. It should be noted that without the sample, a detailed evaluation cannot be made and therefore the possibility of a manufacturing defect in this specific case cannot be assessed. However, such a manufacturing defect remains a possibility.

The insertion technique of Mirena® is unique, and therefore, all health care professionals are encouraged to become fully familiar with the insertion instructions provided in each Mirena package, and to follow them in detail to ensure correct deployment and placement of the IUS. We have previously identified handling errors that can lead to a non-deployment of the IUS. In addition to the insertion instructions provided in the Mirena package, further material and advice, as well as demonstration systems (demonstration inserter with IUS and uterus models), training and support can be obtained via the local sales representatives or upon written request to the local subsidiary.

Jussi Pirjola
Director, Quality Management, Bayer Schering Pharma Oy, The Netherlands

Sarah Cross
Head of Medical Women's Health, Bayer Schering Pharma, Bayer House, Strawberry Hill, Newbury RG14 1JA, UK

References
1 Albertazzi P. Difficult insertion of IUS [Letter]. *J Fam Plann Reprod Health Care* 2007; **33**: 287.
2 Ledbury J, Duncan M. Difficult insertion of IUS [Letter]. *J Fam Plann Reprod Health Care* 2008; **34**: 134.

LNG IUS duration of use

I think the readership of the Journal would be interested in a discussion on intrauterine contraception held at an international meeting in New York, USA in November 2006. The presentations have since been published in a special supplement of *Contraception* in 2007 but the question and answer sessions remain unreported.[1] During this meeting a question was asked concerning the duration of use for the levonorgestrel intrauterine system (LNG IUS). Irvin Sivin and Viveca Odlind were in the audience [authors on several papers reporting randomised controlled trial (RCT) findings that the LNG IUS provides effective contraception for up to 7 years].[2,3] It was confirmed that all these RCTs took place in the 1980s using a LNG IUS prototype. This system released about 20 µg LNG a day (similar to Mirena®, Bayer Schering Pharma) but contained 60 mg rather than 52 mg LNG in the vertical stem. Therefore we need better data investigating the marketed system, Mirena, before concluding that this IUS is effective for 7 years.

Diana Mansour, FRCOG, FFSRH
Consultant in Community Gynaecology, Contraception and Sexual Health Service, Newcastle upon Tyne Primary Care Trust, Graingerville Clinic, Newcastle upon Tyne, UK.
E-mail: Diana.Mansour@newcastle-pct.nhs.uk

References
1 Special issue on intrauterine devices and systems. *Contraception* 2007; **75**: S1–S166.
2 Sivin I, Stern J, Coutinho E, Mattos CE, el Mahgoub S, Diaz S, *et al.* Prolonged intrauterine contraception: a seven-year randomized study of the levonorgestrel 20 mcg/day (LNg 20) and the Copper T380 Ag IUDS. *Contraception* 1991; **44**: 473–480.
3 Barbosa I, Olsson SE, Odlind V, Goncalves T, Coutinho E. Ovarian function after seven years' use of a levonorgestrel IUD. *Adv Contracept* 1995; **11**: 85–95.

Difficult IUD insertions

I write in response to the issue raised by Dr Isabel Draper.[1] I share her sentiments that insertion of intrauterine contraception has become progressively more challenging as we see increasing numbers of nulliparous women requesting a copper intrauterine device (IUD) or Mirena® for contraception plus many older women requesting a Mirena® for gynaecological indications and for hormone replacement therapy. In the community clinic setting, we may have eight or nine such women for intrauterine contraception in a session plus have to balance this with the needs of a training doctor.

Insertion of intrauterine contraception is often deeply unpleasant for nulliparous and older women, particularly if the procedure is being undertaken by an inexpert doctor. A carefully and gently applied intracervical injection of local anaesthetic makes a huge difference to the tolerability of difficult and painful insertions. Local anaesthetic allows for easier insertion of the banded copper IUD or Mirena. In addition, local anaesthetic blocks the vasovagal response which can have an impact on the smooth running of a busy clinic when nulliparous women may languish feeling faint and in pain following IUD insertion without local anaesthetic. In the training situation, if the instructing doctor first inserts the local anaesthetic then the training doctor can then proceed with the IUD or Mirena insertion in a much less stressful situation.

With this in mind, I asked a nulliparous woman last week following her second IUD insertion which was better: with or without local anaesthetic? She said that it was "'a thousand times better" with local anaesthetic.

Ailsa E Gebbie, FRCOG, FFSRH
Consultant in Community Gynaecology, NHS Lothian, Edinburgh, UK.
E-mail: ailsa.gebbie@nhslothian.scot.nhs.uk

Reference
1 Draper IB. Difficult IUD insertions [Letter]. *J Fam Plann Reprod Health Care* 2008; **34**: 67.

J Fam Plann Reprod Health Care: first published as 10.1783/jfp.34.2.134b on 1 April 2008. Downloaded from http://jfprhc.bmj.com/ on April 20, 2024 by guest. Protected by copyright.