acute Trust for removal, where they still re-sterilise instruments.

Do the authors know of a source for the correct single-use instruments, or can a manufacturer be encouraged to develop the appropriate items?

Anne Bennett, MRCGP, MFSRH
Associate Specialist, CASH Service, Chapeltown Health Centre, Leeds, UK.
E-mail: bennetta@nhs.net

Reference
1 Mansour D, Walling M, Glenn D, Egarter C, Graesslin O, Herbst J, *et al.* Removal of non-palpable etonogestrel implants. *J Fam Plann Reprod Health Care* 2008; **34**: 89–91.

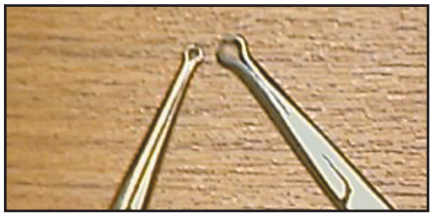

Figure 1 Disposable vasectomy forceps used for Norplant® removal

Reply

We thank Anne Bennett for her comments[1] related to our article describing removal techniques for contraceptive implants.[2]

Many primary care organisations are bringing in 'single-use instruments policies' as a result of new NHS guidance on decontamination aimed at improving the quality of surgical instrument reprocessing across the health care sectors in England. Finding manufacturers who are prepared to supply small numbers of specialist disposable surgical instruments is difficult, however we have good news.

Disposable modified vasectomy forceps can now be obtained for about £2 from the supplier mentioned below. This company is also making disposable 'deep' implant removal kits, which include mosquito forceps and small Langenbecks skin retractors.

Contact: Unisurge International Ltd, Unit N, Dales Manor Business Park, East Way, Sawston, Cambridge CB22 4TJ, UK. Tel: 01223 839911. E-mail: info@unisurge.com.

Diana Mansour, FRCOG, FFSRH
Head of Service, Newcastle Contraception and Sexual Health, Graingerville Clinic, Newcastle General Hospital, Newcastle upon Tyne, UK.
E-mail: Diana.Mansour@newcastle-pct.nhs.uk

Martyn Walling, FRCGP, FFSRH
General Practitioner, Spalding, UK.
E-mail: martyn@belmontdoc.freeserve.co.uk

References
1 Bennett A. Norplant removal forceps [Letter]. *J Fam Plann Reprod Health Care* 2008; **34**: 272–273.
2 Mansour D, Walling M, Glenn D, Egarter C, Graesslin O, Herbst J, *et al.* Removal of non-palpable etonogestrel implants. *J Fam Plann Reprod Health Care* 2008; **34**: 89–91.

Underuse of the IUD

I read the article on the underuse of the intrauterine device (IUD)[1] in the July issue with great interest and noted that none of the references are prior to 1983. That is 25 years ago, however the real blow to the IUD's popularity was in the late-1970s when the Dalkon Shield® was pilloried and vilified as a source of pelvic infection and sterility, on what I believe was false scientific evidence. At that time there was a UK IUD network, organised by Professor R Snowden of Exeter University to which 20 major family planning clinics belonged.

Every device fitted and every subsequent patient visit was recorded and sent to Exeter. In 1977, over 40 000 fittings had been recorded, of which 7282 were Dalkon Shields. There were only two cases of pelvic infection and both were cases known to me in Glasgow: one in a prostitute with gonorrhoea and the other in a woman who had tried to abort herself with a knitting needle. As a direct result of organised adverse publicity, the manufacturers of the Dalkon Shield went out of business and the reputation of all IUDs worldwide suffered a slump from which it has never recovered. A similar campaign against Depo-Provera® was mounted from the USA in the early 1980s and injectable methods never achieved the popularity they deserve for similar commercial reasons. Women are ill-served by 'market forces'.

Elizabeth S B Wilson, MBBS, FFSRH
Family Planning Services Coordinator, Greater Glasgow Health Board 1980–1990, Glasgow, UK. E-mail: libbysbwilson@doctors.net.uk

Reference
1 Edouard L. Contraptions for intrauterine contraception. *J Fam Plann Reprod Health Care* 2008; **34**: 199–201.

Nurse IUD fitting

We are writing to respond to the Personal View article by Cooling and Dunster entitled 'Nurse intrauterine device training' that was published in the July issue of the Journal.[1] We wholeheartedly applaud the positive experience expressed within this article, and its conclusion that "… nurses who are recognised trainers and experienced in IUD insertion to supervise the training of doctors" as this underpins the work the FSRH Associate Nurses Working Group has been undertaking recently. However, we felt the need to respond to the not-so-positive comments about the Royal College of Nursing (RCN) guidance being "absurd in requiring the learner to observe the trainer doing five insertions in patients: one is usually sufficient …". The RCN has been instrumental in the development of guidance in order to enhance and advance nursing practice, and has specifically demonstrated its support in enabling nurses working at a higher or specialist level within the area of contraception and sexual health to undertake the removal and insertion of intrauterine techniques (IUTs) and implants. Without this guidance, nurses who were performing these procedures, or who wished to do so, were opening themselves up to litigation should an error occur. The rationale behind the guidance stating five insertions is in the fact that some nurses (i.e. gynaecology nurses) may not have ever had the opportunity to observe an IUT fitting. It was always understood that those of us who had greater exposure to procedures would not necessarily need this level of observation.

Wendy Moore, RGN, MSc
Vice-Chair, FSRH Associate Nursing Working Group and Clinical Service Manager/Nurse Specialist - Contraception and Sexual Health, Snow Hill Centre, Wolverhampton, UK.
E-mail: wendy.moore@wolvespct.nhs.uk

Reference
1 Cooling H, Dunster W. Nurse intrauterine device training. *J Fam Plann Reprod Health Care* 2008; **34**: 193–194.

Pharmacy-based sexual health services and clinical governance

I read with interest the Editorial by Beth Taylor in the July 2008 issue of the Journal.[1]

I agree that the time is right to develop vision to embrace additional providers of the sexual health service. The new pharmacist's contract is a welcome development in this direction.

As Beth Taylor highlighted, there is certainly a need for educational and training support from specialist services in order to avoid isolation. One way of developing a robust professional link would be the development of a linked Clinical Governance Plan with local specialist services. This will not only assure a safety net but also help in continued development of such services. This would need to be thought out and planned carefully at the primary care trust (PCT) level. Moreover, treatment and patient group directions (PGDs), especially for STIs, would have to be carefully developed in the light of the recent alert on high-level azithromycin resistance in *Neisseria gonorrhoea*. Other issues such as partner notification would also need to be resolved through training input and professional pathway with local specialist services.

Another concern would be the prescription cost for medications, which already are free on the NHS. It would be an opportunity to work with the local PCTs to explore whether they would be willing to support some/all of the costs associated with a pharmacy site for Level 1/2 Sexual Health Service delivery. There are no data on demand for a Sexual Health Service with prescription charge. The uptake of the newly launched online chargeable repeat contraception service would give an indication of clients' willingness to pay for such services.

Ranjana Rani, MRCOG, FFSRH
Consultant in Genitourinary Medicine and Lead Sexual Health, Tameside and Glossop Centre for Sexual Health, Tameside and Glossop Primary Care Trust, Denton, Manchester, UK.
E-mail: r.rani@nhs.net

Reference
1 Taylor B. Developments in pharmacy-based sexual health services. *J Fam Plann Reprod Health Care* 2008; **34**: 143–145.

Treatment of perimenopausal menorrhagia with Implanon®

I write concerning the successful treatment of perimenopausal menorrhagia with Implanon® in a 53-year-old woman. The patient (date of birth early 1953) was seen at the surgery in October 2004 with symptoms of flushing and regular periods. In early 2006 she developed menorrhagia, which was investigated with normal hysteroscopy and intrauterine system (IUS) insertion in early August 2006. The IUS was expelled after 2 months *in situ* and after ongoing symptoms of polymenorrhagia. After some discussion with the patient regarding treatment options, she decided to trial Implanon insertion, aware that it was not a clinically recognised treatment option for menorrhagia. The insertion was carried out in early October 2006. On review in August 2008 the patient noted light bleeds in March and April 2007, and a 2-day light bleed in May 2008. She stated that she "would be willing to recommend Implanon to anybody".

I plan to write to the manufacturer concerned, namely Organon, concerning this important clinical effect of Implanon in the treatment of perimenopausal dysfunctional uterine bleeding. I would be interested to hear if other practitioners have anecdotal evidence of Implanon being used in this way.

Liz Grant, MRCGP, DRCOG
General Practitioner, City Road Surgery, Hulme, Manchester, UK.
E-mail: the_james_family@btinternet.com

LETTERS TO THE EDITOR

Letters to the Editor are welcome and generally should not exceed 600 words or cite more than five references. For comments on material published in the most recent issue of the Journal, correspondence should be received within 4 weeks of dispatch of that Journal to be in time for inclusion in the next issue. When submitting letters correspondents should include their job title, a maximum of two qualifications and their address(es). A statement on competing interests should also be submitted for all letters. Letters may be submitted to the Editor or the Journal Editorial Office (details on page 205).

J Fam Plann Reprod Health Care: first published as 10.1783/147118908786000460 on 1 October 2008. Downloaded from http://jfprhc.bmj.com/ on April 18, 2024 by guest. Protected by copyright.