

Injectable local anaesthetic for IUD/IUS fittings: author's response

Judging by our respective letters,^{1,2} Beth Devonald and I appear to work in different worlds.

1. I find nurse practitioners take to learning techniques of anaesthesia with enthusiasm, unlike Dr Devonald's students who are "most anxious" and "heave a sigh of relief" that they won't have to learn how to give local anaesthesia (LA). The nurses I meet have seen women experiencing strong pain with insertions, something Dr Devonald says she does not recognise, and are delighted to learn techniques of avoiding it.
2. LA is indeed simple, safe and painless to administer. Dr Devonald reports that she and other colleagues have patients who find the injections uncomfortable. This is not my experience, where most women feel nothing and a few feel an odd sensation or dull ache. This minority who feel something report that it is not painful and is certainly less than the discomfort of dental anaesthesia or LA for insertion of a subdermal implant. If this is the case, what then am I doing that others are not? The simple distraction of "Cough!" before the injection or the use of fine dental needles? I fail to understand why practitioners perceive this as a painful procedure.
3. Dr Devonald is inaccurate in saying that LA does not prevent internal os spasm or pain. It does in practice even though theoretically the more dangerous paracervical block

should achieve this better. The current guideline of infiltrating the second and third injections through the external os and directly around the internal os should address this theoretical complaint.³

4. I agree that many general practices are not equipped to do intrauterine device (IUD) fittings as well as we are in clinics with good halogen lighting and lithotomy couches. The issue of poor lighting should be urgently addressed.

One must ask, too, what are the conditions suitable for fitting IUDs but not for using LA? Many general practitioners (GPs) I have worked with are unable to provide a chaperone/assistant. Some do not use Allis forceps to steady the cervix and some do not sound the uterus before the insertion. This is all bad practice but I am glad to say that most GPs I meet do follow Faculty guidelines.⁴

I also agree that adding adrenaline can cause unpleasant palpitations with no benefit. That is why I never use added adrenaline.

5. "Many patients are more worried about the injection." This depends on how it is proposed. I find now that, as it is my default position, instead of asking whether a woman would like to have LA or not that by counselling "We use local anaesthesia for our fittings. Is that all right for you?" women have universally said yes and shown no evidence of worry or fear.
6. Dr Devonald quotes her many GP colleagues and a hysteroscopist, practitioners who never use LA, as a justification of her position. That this continues in the 21st century questions the notion of patient centredness and I could indeed take as a justification of my own position.
7. Dr Devonald does not have the same experience that I do of bad pain for some and vasovagal symptoms for others. Once again we appear to be working in different worlds. She claims my figure of 96% with no problems post-insertion is equivalent to hers without LA. Whether the use of anaesthesia decreases post-insertion problems as I am claiming should therefore be debated.
8. We all recommend the use of an analgesic before the fitting but as Dr Devonald admits this has no effect on the pain of insertion and only deals with the post-insertion cramping.

My working days are filled with women who have had IUD fittings with and without anaesthesia. Without exception they say what a different experience it is with anaesthesia, comfortable and with none of the pain many report from the previous procedure. It must be noted

of course that fundal cramping, at times considerable, remains untouched by LA.

I have been fitting IUDs with LA since 1972. I started with plain 10 ml syringes and certainly find the dental syringes and needles much better. If GPs argue that using dental syringes is too expensive, then they could use the cheaper but bulkier 10 ml syringes.

I will repeat my argument that if the dental profession has made the use of LA the default position then why not us? How many women – in my world if not in Dr Devonald's – will have to suffer unnecessary pain before we make it the default? Remember any woman, *but not any practitioner* as is the case at the moment, can opt out of it.

Finally, as we argue among ourselves, let us not lose sight of the fragile notion of putting patients first. Why not ask them what they want instead of deciding for them? For years as a profession we have paid lip service to a patient-centred approach while too often in practice we remain self-regarding. If this is the prevailing reality then I am indeed happy to be out of step.

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