

LETTERS

Libido, sexuality and the levonorgestrel IUS in Malaysia

Madam,

Hysterectomy and tubal sterilisation are two commonly performed gynaecological procedures in Malaysia. Little has been published about the psychological impact on sexuality of such operations in the Far East.

Many Malaysian patients believe that surgery to the pelvic organs may be detrimental to the sexual health and needs of women. There is a widespread belief that the uterus is essential for the libido and sexual wellbeing of women. It is also believed that tubal sterilisation may result in the loss of libido and thus of sexual desire for her husband.

Despite counselling to dispel these misconceptions, patients frequently refuse surgical management for fear of losing their libido and sexuality. Inability to satisfy and consummate marriage is a valid reason for the partner to find another wife (Muslims in Malaysia are legally allowed to have four wives). This fear of ultimately losing the husband to another woman due to lack of libido and loss of sexuality often causes women to refuse appropriate surgery.

The recent availability of the levonorgestrel intra-uterine system (IUS) in Malaysia provides a suitable medical alternative to surgery in managing some of these patients. There is good evidence to suggest the effectiveness of the levonorgestrel IUS in the treatment of menorrhagia. The use of the levonorgestrel IUS in women whose cultural beliefs/misconceptions are not amenable to counselling, may help in the psychological preservation of their libido and sexuality.

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Management of menorrhagia

Madam,

We read with interest the paper by Turner et al on the management of menorrhagia in primary care, suggesting that the majority of Forth Valley GPs practice in line with the recent RCOG recommendations.¹ We, and our colleagues, recently carried out a prospective study of the management of 885 women consulting with menorrhagia in primary care in Somerset, using patient-based morbidity data collected by a representative sample of practices.²

In our study, levels of prescribing of effective drugs (tranexamic acid and mefenamic acid) and levels of appropriate investigation (vaginal examination and full blood count) fell well short of those found by Turner et al. For example, in Somerset just 15% of women received tranexamic acid and 27% mefenamic acid, whereas in the Forth Valley two thirds of GPs prescribed these drugs as first or second choice for women not requiring contraception. In addition, in Somerset vaginal examination and full blood count were performed on 42% and 39% of women, respectively, compared to 56% and 52% in Scotland.

Interestingly, in the Somerset study, 23% of women with menorrhagia received no drug treatment in primary care, compared to just 1% in Scotland. In this respect, management of menorrhagia in the Somerset study may be more in line with RCOG guidelines, which suggest that up to one third of women with menorrhagia

could benefit from reassurance rather than receiving drugs or referral.³

One of the likely explanations for this apparent marked geographical variation in the management of menorrhagia is that GPs' self-reported actions do not necessarily reflect what they actually do in practice.⁴ Turner et al acknowledge this as a limitation of their study, and plan to carry out a more objective investigation of GPs' practice locally. Such future research should explore first whether there is an association between individual GP's self-reported and actual practice and, second, whether actual practice is more consistent with that found in Somerset. If this was not the case, it would be interesting to investigate whether regional differences in rates of effective management impact on rates of referral to gynaecology and subsequent hysterectomy, as has been postulated.⁵

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References

- 1 Turner E, Bowie P, Kellock C. First-line management of menorrhagia: Findings from a survey of general practitioners in Forth Valley. *The British Journal of Family Planning* 2000; **26**: 227-228.
- 2 Grant C, Gallier L, Fahey T, et al. Management of menorrhagia in primary care - impact on referral and hysterectomy: data from the Somerset Morbidity Project. *Journal of Epidemiology and Community Health* 2000; **54**: 709-713.
- 3 Royal College of Obstetricians and Gynaecologists. *The initial management of menorrhagia*. London: RCOG Press, 1998.
- 4 Eccles M, Ford G, Duggan S. Are postal questionnaire surveys of reported activity valid? An exploration using general practitioner management of hypertension in older people. *British Journal of General Practice* 1999; **49**: 35-38.
- 5 Effective Health Care. The management of menorrhagia. *Effective Health Care Bulletin* 1995; **9**: 1-14.

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