

LETTERS

What's in a name?

Madam,

The new name for the Journal is entirely appropriate, but please don't omit 'Family Planning' from the title.

We in the developed world are the role models for the developing world. They look to us for guidance. In the developing world, 'Family Planning' means just that. It is a respectable phrase which is accepted and recognised in many languages. We owe it to them not to alter the name.

Who would benefit from a change? Not our client groups - I don't think the phrase 'sexual health' will mean anything to younger people, and the term is very likely to alienate older women.

I have a feeling that the professionals are the only ones who would benefit from our use of a more scientific name, since it would make them feel more acceptable to their colleagues as 'proper' and 'scientific' doctors.

When the original NAFPD was formed, the debate ranged long and hard over the name of the association. Fortunately, we did not adopt 'Organisation for Reproductive, Gynaecological And Sexual Medicine' (ORGASM).

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Lesson of the week – Norplant failure

Madam,

A 32-year-old woman (weight 60 kgs) presented with pelvic pain and vaginal bleeding. Four weeks earlier she had had a Large loop excision diathermy of the transformation zone of the cervix (LLEDTZ) for severe dyskaryosis. A Norplant contraceptive had been inserted 3 years earlier and she had had irregular menstruation.

An initial diagnosis of pelvic infection related to the cervical treatment was made, but surprisingly a pregnancy test was positive. An ultrasound scan revealed a gestational sac outside the uterus and a laparoscopic salpingectomy was performed for a tubal ectopic pregnancy. She made an excellent recovery from the procedure. Her faith in the Norplant is somewhat shaken, however, and the couple are planning to use condoms for extra contraception protection whilst her husband arranges a vasectomy.

This is the first pregnancy we have seen locally with experience of over 330 Norplant insertions. The reported Pearl index for Norplant is 0.2/100 woman years. The timing of this pregnancy suggests that a reduction in the protective cervical mucus caused by the LLEDTZ allowed pregnancy to occur.

Unlike Norplant, Implanon inhibits ovulation and effects on cervical mucus are not a major consideration. At present, however, we still have many women using Norplant for contraception. Should we be advising them and users of the progestogen-only pill that additional barrier conception should be used during a cycle where cervical treatment is planned? We look forward to hearing other readers' thoughts on this issue.

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Twenty-five years ago: Then and now

Madam,

In the early days family planning clinics were started and operated by women on a voluntary basis. The doctors and nurses were paid on a sessional basis. A nominal consultation fee was charged and the profits from the sale of the contraceptives issued at the clinics provided the income to pay the professional staff.

I was one of those women who, in 1964, started a new clinic in Chobham, Surrey, UK, with the support from volunteers in the Epsom clinic. In 1968 these clinics were incorporated into regional centres, my clinic coming under Guildford.

In 1968 I came to Australia and on similar lines started Family Planning Queensland.

Marjorie Millburn, Administrator

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Fibrosis attached to the tail of a levonorgestrel intra-uterine system

Madam,

Intra-uterine devices (IUDs) are the most popular modern contraceptive in Turkey, used by nearly 20% of the women of reproductive age.¹ At the clinic of the Woman and Child Health Training and Research Unit of the Medical School of Istanbul we insert nearly 1000 IUDs each year. We are also a referral centre for problems and complications that arise with IUDs fitted by other family clinics on the European side of Istanbul - a region with nearly five million inhabitants. Lost IUD threads are therefore a common problem referred to our clinic. We usually remove all IUDs without visible threads, using either alligator forceps or a hooked IUD remover. This is performed as an outpatient procedure and without much difficulty.

On November 25th 1999, a 25-year-old multiparous woman was referred who had a levonorgestrel intra-uterine system (IUS) inserted 17 months previously; the threads of the device could not be visualised. An ultrasonography was performed and it was confirmed that the IUS was in a fundal position within the cavity. It was decided to leave the device in place and to follow the client according to our routine schedule. Twelve months later the device was removed at her request. The removal was achieved easily using alligator forceps, although a slight resistance could be felt.

When the IUS was removed, a blue-grayish, shiny mass 1.5 cm in diameter was attached to its lower end (Figure 1). This was a finding we have never observed before with copper bearing devices. The IUS, with its attached mass, was sent to pathology and reported as: 'foreign body reaction: fibrosis which contains dominantly collagen fibres and to a lesser extent capillary formations can be observed. Granulation tissue of young elements of connective tissue, foreign body giant cells and inflammatory cell infiltrations'.

Figure 1



The typical histological changes reported with the levonorgestrel-releasing IUS are thinning of the endometrium with glandular atrophy and decidualisation of the stroma.²⁻⁴ The case we have described has led us to think that it is important to collect and report data on the status of strings or 'missing' threads of levonorgestrel-IUS.

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- 4 Pakarinen PI, Lahteenmaki P, Lehtonen E, et al. The ultrastructure of human endometrium is altered by administration of intrauterine levonorgestrel. *Human Reprod* 1998; 13(7): 1846-853.

Will women stop HRT prior to mammographic screening?

Madam,

Concerns exist that hormone replacement therapy (HRT) reduces the sensitivity of mammographic screening.¹ This therefore raises the issue of whether HRT should be discontinued prior to mammography in order to improve both the sensitivity and specificity of the screening procedure. The issue is twofold: first, for how long would women need to stop taking HRT and, second, would they be willing to do so?

In a large community menopause clinic, 100 women aged 50-65 years (who were already taking HRT for relief of menopausal symptoms) were given a questionnaire asking how long they would be prepared to stop HRT for if they were told that it would make interpretation of their mammogram easier. The results are shown below (Table 1).

Table 1 Results of questionnaire

Duration of time willing to stop HRT	Number of Women N = 100
None	13
1 week	14
1 month	39
3 months	19
6 months	5
9 months	1
1 year	6
Don't know	3

This small study suggest that 66% of women taking HRT would not be prepared to stop treatment for more than 1 month before mammography, while 31% would be willing to stop for 3 months or longer. At the present time, it is uncertain exactly how long it would take to reverse the mammographic changes that are induced by HRT (10-30 days). The regression of hormone-induced mammographic changes potentially improves mammographic specificity and thus helps to avoid unnecessary biopsy.²

There is an urgent need for a large prospective study looking into the effect of stopping HRT on mammographic density before we attempt to persuade large numbers of women to temporarily discontinue HRT prior to breast screening.

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Experiences of termination of pregnancy in a stand-alone clinic

Madam,

We read the article by Boorer and Murty¹ with great interest, and believe that it highlights a major discrepancy in the provision of NHS care. We believe that termination of pregnancy (TOP) under local anaesthetic should be available to all women requesting termination, as part of a wider choice of methods within a NHS setting.

We are grateful to Boorer and Murty for their account of safety, simplicity and effectiveness of local anaesthetic Manual Vacuum Aspiration (MVA) in first trimester TOP. They were amongst the pioneers of the introduction of this ground-breaking technique into the UK, and in the provision of services outside of hospital settings. After performing over 2000 MVA procedures in stand-alone charitable clinics, we have now introduced the technique into our NHS hospital practice. We therefore feel well positioned to add to the positive observations of Boorer and Murty.

The key to a 'woman-centred' TOP is 'choice' in all aspects of provision. Part of this 'choice' is the tailoring of methods to individuals. We believe that all women undergoing TOP should have a choice of all suitable available methods. When a woman has made her choice, the technique that she has chosen can then be developed to meet her individual needs. For example, MVA can be made even more acceptable by offering women a choice of analgesia. The British Pregnancy Advisory Service (BPAS) studied their first 500 women having MVA. They found that 22% chose to use N₂O/O₂ (Entonox). Of these, 86% found it helpful. Within the BPAS, nurses are now recommended to routinely offer Entonox to their MVA patients. The levels of pain and bleeding for this technique compared favourably with early medical TOP.²

MVA can also be tailored to the woman's needs in other ways. In addition to the injection of lignocaine into the cervix to produce either an intra-cervical or para-cervical block, lignocaine

gel can be used during the dilation process. Other modifications to the MVA technique include: the rare use of flexible tapered plastic dilators; the exceptional use of intra-venous oxytocics; and the very occasional use of an electric suction pump. Our experiences of the technique within TOP clinics in Holland have demonstrated to us the value of encouraging the woman to bring a partner or friend with her to make the experience more acceptable. In Holland the women are encouraged to view the products of conception at the end of the procedure, and this seems to be very useful for many women in coming to terms with the procedure. Once again, choice must be offered here.

The environment in which the procedure is carried out is very important. The room should be light and airy with the minimum amount of medical equipment on display. Team-work is also of vital importance. All members of the team should be committed to the women's health care issues. Of particular importance is the nurse who accompanies the woman through the procedure. An appropriately caring attitude by this nurse is often the most important part of the technique.

Since introducing local anaesthetic termination as a choice for our NHS patients, we have been anxious to monitor the acceptability of the technique. Early indications seem to confirm the acceptability of MVA compared with medical termination. Patients undergoing MVA have scored median values for pain of four (visual analogue score, 1 = no pain, 10 = severe pain), compared with patients undergoing medical termination who scored median values for pain of six. When asked if their experience of MVA were better or worse than expected (visual analogue scale, 1 = better than expecting, 10 = worse than expecting) the median score was three.

We find that each procedure is as individual as the woman requesting the technique is. All women should have an informed choice of method of TOP. This choice should be easily available within an NHS setting.

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Re: Stage Ia endometrial carcinoma diagnosed on removal of an IUD

Madam,

It was interesting to read the above case report¹ by Dr Kay in the April 2001 issue of the Journal. However the coincidental findings of an endometrial carcinoma at the time of removal of an IUD is not an entirely uncommon event. I accept that there is no overall increase in the incidence of the disease with IUD use. However, the issue as to whether there is an association with long-term use without a change of device has not been addressed. The case reported had a 20-year history of use without change.

Similarly my case report² and brief review by Ojutiku and Morcos notes the development of a squamous cell carcinoma of the endometrium following 25 years of IUD use without change. Despite the possible protective role noted by Parazzini et al,³ it is difficult to see how a chronic inflammatory response would not eventually lead to some degree of cytological atypia. I am also yet to see a plausible mechanism for protection. In addition, the relative hypo-oestrogenic environment of the menopause may also play a role in its development. I feel strongly that postmenopausal patients with a history of long-term IUD use without change should, where symptomatic, be investigated with a high level of suspicion.

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