

LETTERS

WHO recommendations

Madam

May I congratulate the Journal and the Clinical Effectiveness Unit for continuing to produce excellent Guidance for those of us working in the field of reproductive health. The wide dissemination of these articles will ensure uniformity and quality in contraception provision in primary and secondary care.

I have, however, one concern. This has been alluded to in a recent article describing the consensus process for adapting the World Health Organization (WHO) *Selected Practice Recommendations for UK Use*.¹ As a result of the relaxation of some of the more cautious rules a very small number of women may become pregnant. An obvious example is giving Depo-Provera® injections 2 weeks late (i.e. at 14 weeks) without any precautionary measures. The *Selected Practice Recommendations for Contraceptive Use*² were developed to improve and extend contraceptive provision in developing countries. In developed countries, however, those becoming pregnant may take a more litigious view particularly when patient information leaflets and the Summaries of Product Characteristics (SPCs) state contrary and more cautious advice. In addition, new evidence regarding follicular development potential suggests that more, rather than less, caution may be advisable.³ Could the Faculty of Family Planning and Reproductive Health Care or the University of Aberdeen be sued?

As these Guidance documents are often used in isolation, health professionals may think that the new advice is as 'safe' as previous practice. A statement after each new 'expert consensus' recommendation, similar to the Bulletin Board wording,⁴ would alert readers and highlight the need for caution in those where an unplanned pregnancy would be a disaster. The wording is given below:

"Relaxing the traditional rules may facilitate the use of effective methods by couples in developing countries where pregnancy is associated with high maternal and perinatal morbidity and mortality. The relaxation of these rules in developed countries, however, may lead to unintended pregnancy in a very small number of women. A pragmatic approach to contraceptive provision should be taken and this small increased risk discussed with individual women."

Personally I think consultation times are too short to cover theoretical risks of different starting regimens for pills, or antibiotic cover for the fitting of intrauterine contraceptives in those at risk of bacterial endocarditis. Surely we should be stating best safe practice where there is evidence and then discussing areas where relaxation of the rules, with user involvement, will individualise care?

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References

- 1 Glasier A, Brechin S, Raine R, et al. A consensus process to adapt the World Health Organization *Selected Practice Recommendations for UK Use*. *Contraception* 2003; **68**: 327-333.
- 2 World Health Organization (WHO). *Selected Practice Recommendations for Contraceptive Use*. Geneva, Switzerland: WHO, 2002.
- 3 Baerwald AR, Adams GP, Pierson RA. A new model for folliculogenesis during the menstrual cycle in women. *Fertil Steril* 2003; **80**: 116-122.
- 4 Bulletin Board. *J Fam Plann Reprod Health Care* 2003; **29**(3): 169.

Service standards for sexual health

Madam

Two cheers to the Faculty for producing these useful Standards,¹ which should assist providers to make the case for adequate resources to meet the needs of our populations. The only difficulty I see is the essential (minimum) requirement not only to document the offer of a chaperone for intimate examinations but also, if the offer is 'accepted or declined, this should also be clearly recorded in the notes including the name of the chaperone'.

We all agree that patients should consent to being examined and chaperones should be offered. However, this level of documentation detracts from patient care and listening to our clients. It is a trend to defensive medicine which lawyers will still find a way around to sue us. We do not need the Faculty to provide a convenient noose for us to be hung by if we should fail to document everything. At a recent meeting of consultant colleagues, it was suggested that when fitting an intrauterine device (IUD), we should record details including 'cervix grasped with forceps'. Where next? Why not require documentation of gloves worn, speculum inserted, cervix visualised, swabbing of cervix, etc, etc?

I appreciate the Faculty are in some difficulty. The General Medical Council (GMC) Standards² say we should not only record that the offer of a chaperone was made, but also if a chaperone is present we should record that fact and make a note of the chaperone's identity. In addition, the GMC say we should record that permission has been obtained before the examination. How many readers record this?

The Royal College of Obstetricians and Gynaecologists³ only consider that obstetricians and gynaecologists should offer chaperones irrespective of the gender of the gynaecologist, and if the patient prefers to be examined without a chaperone then this should be recorded in the notes.

I am keen to know how many colleagues would find implementing this standard forced us away from patient care and provided a potential tripwire for us to be caught on?

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References

- 1 Faculty of Family Planning and Reproductive Health Care Service Standards for Sexual Health Services, September 2003. <http://www.ffrhrc.org.uk>.
- 2 General Medical Council (GMC) Standards on Intimate Examinations, December 2001. <http://www.gmc-uk.org>.
- 3 Royal College of Obstetricians and Gynaecologists (RCOG) Intimate Examinations. Report of a Working Party, September 1997. <http://www.rcog.org.uk>.

GyneFix® insertion

Madam

The development of the new (Mark 2) introducer is an attempt to facilitate the insertion procedure of the GyneFix® intrauterine device. The initial clinical results with this inserter have been highly encouraging but, over time, doctors have reported us some failed insertions that they usually did not experience with the previous type (Mark 1) inserter. Although many group practices and individual doctors are happy with the new introducer, we recommend to those who experience failures to continue to use the Mark 1 inserter with which they have become familiar. Supply of the Mark 1 inserter will therefore continue. We recommend that doctors follow the instructions for insertion strictly as this leads to almost a negligible failed insertion and expulsion rate as was recently experienced in a new study with GyneFix, which is to be published in the March 2004 issue of the

journal, *Contraception*.¹ Video films of both Mark 1 and Mark 2 GyneFix insertion procedures are demonstrated on the Control Research website (www.control.be). Please take advantage of these highly useful recommended insertion instructions. Doctors who have no access to the Internet can contact us to receive a CD-ROM of the insertion procedure.

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Reference

- 1 Cao X, et al. Three-year efficacy and acceptability of the GyneFix®200 intrauterine system (IUS). *Contraception* 2004; **69**: (in press).

GyneFix® fitting

Madam

I would like to give some background information as the clinician who fitted the GyneFix® in the patient who had a GyneFix intrauterine device (IUD) removed from her bladder.¹ Just when did the perforation and translocation occur (Table 1)?

Table 1 Timeline of events

Date	Event
October 1994	Oral EC
March 1995	Oral EC and DMPA injections until September 1997
September 1997	Did not attend for injection
November 1997	Oral EC
June 1998	Oral EC and DMPA injection
June 1999	Emergency GyneFix®
August 1999	Did not attend for GyneFix check
January 2000	Colposcopy. No mention of thread being seen; sketch of cervix does not show threads
June 2000	Did not attend colposcopy follow-up
August 2000	Did not attend for GyneFix check
June 2001	Did not attend for GyneFix check
September 2001	Urinary symptoms start
March 2002	Ultrasound shows GyneFix in the bladder
April 2002	GP phoned to discuss the patient
July 2002	GyneFix removed
September 2002	Implanon® fitted

DMPA, depot medroxyprogesterone acetate; EC, emergency contraception; GP, general practitioner.

The colposcopy clinic notes, made 5 months after the device was fitted, include the history that the patient had a GyneFix. However, the record makes no mention of the presence or absence of the threads, so it is impossible to know if the IUD was not seen, or whether it was present but not recorded. If it was not present, does the colposcopy clinic have a responsibility to refer the patient back for investigation of the positioning of the device?

The perforation might have been noticed sooner had the patient attended her follow-up appointments as scheduled. Should the clinic have chased her up more to attend? A 21-year-old adult, who is competent to give consent to an IUD fitting, should be able to make her own decisions about whether or not to attend follow-up appointments. Most clinics follow the principle that patients attend when they have problems – but should the follow-up be more proactive?

Perforations will always occur – the accepted rate is 1 in 1000 – and clinicians must be ready to investigate the possibility.

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Reference

- 1 Eskandar OS, Eckford SD. Intravestral migration of a GyneFix® intrauterine device. *J Fam Plann Reprod Health Care* 2003; **29**(4): 237-238.