Reply

Madam

I agree with the point made by Dr Peter Bowen-Simpkins that the recommendation made in our case report,[1] namely that if a small fragment of an intrauterine contraceptive device (IUD) is found to be missing and cannot be retrieved hysteroscopically or laparoscopically, a laparotomy should be done, is not evidence-based practice.

Fragmentation of an IUD frame is a rare complication. The possibility of the fragment perforating the uterine muscle, leading to perforation of intestine, although remote, has been suggested by Kabrowski et al.[2] in their case report.

I also agree that the case report does not justify the recommendation of a laparotomy as a routine practice in situations where the missing IUD fragment is not found on diagnostic hysteroscopy or laparoscopy. Due to lack of conclusive data, currently, the risks of extensive surgery certainly outweigh the theoretical risk of intestinal perforation in the situations outlined above. However, each case should be assessed individually and involve full discussion of the merits of conservative management against surgical exploration. The wishes of the woman involved should also be considered in the consultation.

A A Nadgir, MRCOG, DFFP
Associate Specialist, Contraception and Reproductive Health Sciences, Middlesbrough PCT, 23–27 Middlesbrough Road, South Bank, Middlesbrough, Teesside TS6 6NW, UK. E-mail: anagha.nadgir@nhs.net

References
1 Nadgir A, Beere D, Barker K. Intrauterine fragmentation of Gyne T380®: an uncommon complication. *J Fam Plann Reprod Health Care* 2004; **30**: 175–176.
2 Kabrowski B, Schneider HP. Removal of an occult intrauterine fragment of an intrauterine device under hysteroscopic control [German]. *Gynakol Rundsch* 1986; **26**: 210–214.

Cerazette for premenstrual tension

Madam

I have used Cerazette® to manage a patient who was not sexually active but suffered from severe premenstrual tension that had not responded to lifestyle and dietary measures, alternative therapies and fluoxetine. She had classical premenstrual syndrome (PMS) with psychological (irritability, anger, depression) and physical symptoms (breast enlargement/tenderness and bloating). All symptoms responded within the first 3 months of treatment with Cerazette. The patient had an initial 3-day bleed followed by amenorrhoea. She remains amenorrhoeic 1 year later with total clearance of her PMS. I would be interested in readers' experience of the use of Cerazette for PMS and whether a therapeutic role has been observed in women who continue to menstruate.

Ali Kubba, FRCOG, MFFP
Consultant Community Gynaecologist, Reproductive and Sexual Health Services, Mawbey Brough Health Centre, 39 Wilcox Close, London SW8 2UD, UK and Honorary Senior Lecturer, Guy's, King's College and St Thomas's School of Medicine, Department of Obstetrics and Gynaecology, London, UK

BULLETIN BOARD

NEWS ROUNDUP

HIV risk taking

A study using computer-assisted self-interviews looked at HIV risk-taking in sexual health behaviour amongst 257 urban young women.[1] Unsurprisingly this showed that pressure to satisfy a male partner was associated with taking sexual risks, as was imbalance of power with sexual coercion. Lack of trust between partners was also associated with risk-taking. Sensation seeking was associated with taking risks of HIV infection. The author suggested incorporating thrill and excitement in health promotion activities – but this seems unlikely to appeal in the same way. Hey – come and have some really exciting safe sex in a condom? I can't see it catching on.

Reference
1 Jones R. Relationships of sexual imposition, dyadic trust, and sensation seeking with sexual risk behavior in young urban women. *Res Nurs Health* 2004; **27**: 185–197.

Sexual health risks in women who have sex with women

Clinicians may not think about taking a reproductive history from women who identify themselves as lesbian or women who have sex with women. This study looked at 392 women who identified themselves in this way and volunteered to fill in a questionnaire.[1] One in four of the women had been pregnant. In the women younger than 25 years, two-thirds had terminated the pregnancy. More than half of the women were using, or had used, oral contraceptives. So beware, this group may not be as low risk (from sexual health harm) as clinicians sometimes imagine.

Reference
1 Marrazzo JM, Stine K. Reproductive health history of lesbians: implications for care. *Am J Obstet Gynecol* 2004; **190**: 1298–1304.

Gel protection against STIs

Tests of a new gel show it may work against a wide range of diseases, including chlamydia, herpes, hepatitis B and HIV. The International Planned Parenthood News site (http://ippfnet.ippf.org/pub/IPPF_News/News_Details.asp?ID=3530) reports that the first clinical trial is about to be completed and is expected to show good protection against HIV transmission. Animal studies also showed good protection against other STIs. Other vaginal preparations are also under trial.

Vaginal rings for contraception

Vaginal rings are made of soft, flexible, silicone rubber and release hormones that slowly disseminate and are absorbed from the vagina. Depending on the type of ring used, prolonged hormone release may occur from 3 weeks to 1 year. The advantages of the vaginal ring method are that it is user-controlled, does not interfere with intercourse, does not require daily intake of a pill, and allows continuous delivery of a low dose of steroids. The Population Council has developed a progesterone-releasing ring, which is currently on the market in Chile and Peru for contraception in breastfeeding women. Trials of a contraceptive ring releasing very low doses of the potent progestogen, Nestorone® for 6 to 12 months are also under way. Other ring formulations, however, contain hormone combinations that provide excellent contraceptive efficacy with few side effects and good control of menstrual bleeding. The Food and Drug Administration in the USA has recently approved a monthly ring releasing etonogestrel and ethinylestradiol. The Population Council is developing a 1-year contraceptive ring releasing low doses of Nestorone and ethinylestradiol. Combination rings are associated with very low pregnancy rates and side effects consistent with those of combined oral contraceptives.[1]

Reference
1 Johansson ED, Sitruk-Ware R. New delivery systems in contraception: vaginal rings. *Am J Obstet Gynecol* 2004; **190**(4 Suppl.): S54–S59.

The final cut

One in five women in Britain uses sterilisation as their method of contraception. A survey of 12 000 women in Britain, France, Germany, Italy and Spain indicated that the average for the five nations was one in 10, and in Italy less than one in 100 use sterilisation as a form of birth control. The study also found that the average age of sterilisation in Britain was 32 years, 2–3 years younger than women in other countries. Out of the 2500 British women interviewed, 6/10 of them felt that they had not been adequately informed of alternative and reversible forms of contraception such as the pill, coil or condoms. A take-home message for all who refer for, or perform, sterilisation. Further information is available at http://ippfnet.ippf.org/pub/IPPF_News/News_Details.asp?ID=3572.

Calls for resources for GUM

The Health Protection Agency published the most recent figures for sexually transmitted infections (STIs) in July.[1] The report pointed out that new cases of STIs continue to rise and unsafe sexual practices contributed to this. More people coming forward for testing contributed to the increases in numbers identified but this puts an enormous pressure on genitourinary medicine (GUM) clinics. Some successes such as falls in the numbers of people with gonorrhoea, genital warts and herpes were recorded. Both the chairman of the British Medical Association[2] and the president of the British Association of Sexual Health and HIV (BASHH)[3] called for better resources to provide prompt testing and treatment. The present long waiting lists at GUM clinics increases the risks of infections being spread while people wait for testing. Attempts to transfer any of this burden to primary care and community clinics are doomed to failure unless additional resources, trained health professionals and time are available.

References
1 http://www.hpa.org.uk.
2 http://www.bma.org.uk.
3 http://www.bashh.org.

Sterilisation techniques

EngenderHealth has produced two new guides on sterilisation for women and vasectomy for men. Minilaparotomy, which is performed as an outpatient procedure, is a safe, effective and accessible female sterilisation method. 'Minilaparotomy for Female Sterilization' is an illustrated, step-by-step guide to the procedure. In addition to guidelines for recommended surgical techniques (both suprapubic and subumbilical minilaparotomy), the guide provides information on counselling, appropriate preoperative client assessment, infection prevention, pain management and proposed sedation regimes, and prevention and management of surgical emergencies.

'No-Scalpel Vasectomy' is a step-by-step guide for surgeons who perform this male sterilisation method. No-scalpel vasectomy (NSV) is performed without a knife; the surgeon makes only a small puncture in the skin, significantly decreasing pain and recovery time. EngenderHealth has trained doctors in more than 40 countries in the technique, and the NSV illustrated guide, which was first published in 1992, is one of the agency's most successful and widely used publications. This third edition