

I would be grateful for the authors' thoughts on this matter.

Shaur Khawar Qureshi, MRCOG

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Reference

- 1 Anderson J, Gunn E, Hunter M, Owen P. Documentation of preoperative counselling for female sterilization: a complete audit cycle. *J Fam Plann Reprod Health Care* 2005; **31**: 24-25.

Reply

Dr Qureshi's interest in our article is most welcome. The results of the audit from Dr Qureshi's unit suggest that the introduction of a standardised proforma might be expected to improve compliance with RCOG guideline recommendations.

As regards to whether the procedure is called 'laparoscopic tubal occlusion' or 'laparoscopic sterilisation', whilst the former may be more precise, the latter is likely to be more easily recognised as an identifiable procedure by most of our patients. Preoperative counselling is an exercise in communication and we should strive to use the terminology that is most easily understood by our patients.

The publication of the consent advice from the RCOG postdated our audit, so quoting a risk of dying from the procedure was not included as an auditable standard. Whilst there should be no difficulty in explaining that the procedure must be considered irreversible, I agree that to then discuss the availability and results of sterilisation reversal seems contradictory. This latter dilemma is not an issue locally since our Health Board do not permit us to perform sterilisation reversal procedures.

Philip Owen, MD, MRCOG

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Pelvic examination for detecting ovarian cancer

I was very disappointed to read Gill Wakley's website review in the last issue of the Journal.¹ Have we finally abandoned clinical common sense on the altar of guidelines and evidence-based medicine?

Nobody with any sense would advise a pelvic examination as a means of detection of ovarian cancer. The main reason for performing a bimanual examination prior to taking a smear is to enable that examination to be easier and more comfortable for the patient. It enables the smear taker to choose the correct speculum (extra long, virgin, etc.) and hopefully to locate the cervix at the first attempt. How else would one know that the uterus was sharply retroverted and the cervix anterior behind the pubic symphysis? Repeatedly opening and closing the speculum in an attempt to find the cervix is very uncomfortable (I have been on the receiving end!). If one can locate the cervix first time, the procedure is much easier for everybody. I have lost count of the number of women who have said: "Is that all? Last time it took much longer".

A bad experience having a smear taken is often a reason for patients declining further screening.

Of course, all sorts of valuable information can be gained by a pelvic examination. Discomfort can prompt tactful questioning about dyspareunia, which is often not presented as a symptom. If the uterus is enlarged, direct questions about menorrhagia may elicit symptoms that have not been directly complained about. I have even found the odd retained tampon that may account for symptoms. As a hospital gynaecologist, I have on several occasions seen women referred with retained tampons that had not been detected as a speculum often pushes the tampon out of the way but does not discover it.

Then, of course, if one did find an ovarian cyst, would it not be better for the woman if it were found and acted on regardless of whether it is malignant?

I will continue to advise trainees that I think the bimanual examination is part of the taking of a smear ... but then I don't write the guidelines!

Beth Devonald, MRCGP, DFFP

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Reference

- 1 Wakley G. NLH primary care question answering service [Website Review]. *J Fam Plann Reprod Health Care* 2005; **31**: 212.

Reply

There appear to be two main issues raised in this letter.

First, the website review is reporting the answer to a specific question. Dr Devonald raises another question by suggesting that the guidelines for taking a cervical smear should be altered to include a digital vaginal examination to establish the position of the cervix, before inserting the speculum. This would make an excellent question for the NELM primary care question service, namely: 'By how much does a prior vaginal digital examination impair the accuracy of a cervical smear sample?' If the answer is that it does not, then there are training implications for the many nurses who take cervical smears but have not been trained to carry out a digital vaginal examination.

Second, Dr Devonald goes on to suggest that although it cannot reliably detect ovarian cancer, a pelvic examination is useful. But useful for what?

An examination on a patient without symptoms is a screening test and it is quite clear from the literature that a pelvic examination fails the criteria for a screening test.^{1,2} For example, it does not identify reliably, at an early stage, conditions that can be treated to prevent progression. It may do harm by identifying conditions that are not significant and expose the patient to unnecessary further investigations. It may do harm by giving false reassurance of normality.

As a preliminary investigation of a patient with symptoms, it may sometimes be useful, but is not accurate enough to preclude further investigation of symptoms by other means such as ultrasound or laparoscopy.^{3,4}

A large number of questions and answers now appear in the women's health section of this NELM service,⁵ many of which health professionals will find instructive and useful, as they are based on real clinical problems.

Gill Wakley, MD, MFFP

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- 1 Cochrane AL, Holland WW. Validation of screening procedures. *Br Med Bull* 1971; **27**: 3-8.
- 2 Grover SR, Quinn MA. Is there any value in bimanual pelvic examination as a screening test? *Med J Aust* 1995; **162**: 408-410.
- 3 Carter J, Fowler J, Carson L, Carlson J, Twigg LB. How accurate is the pelvic examination as compared to transvaginal sonography? A prospective, comparative study. *J Reprod Med* 1994; **39**: 32-34.
- 4 Nezhat C, Santolaya J, Nezhat FR. Comparison of transvaginal sonography and bimanual pelvic examination in patients with laparoscopically confirmed endometriosis. *J Am Assoc Gynecol Laparosc* 1994; **1**: 127-130.
- 5 <http://www.nelh.nhs.uk/>.

Copying clinic letters to patients

I read with interest Anna Glasier's contribution to Personal View in the April edition of the Journal.¹

Whilst noting that she found it difficult to draw precise conclusions from her small project, I should like to add our own findings from a more

general patient population to support her impressions.

We conducted an audit into the system for 'Copying Letters to Patients', which had been set up at Barnsley Hospital NHS Foundation Trust in response to the Department of Health Initiative first noted in the NHS Plan.² Our findings mirrored those of Anna Glasier in that patients were enthusiastic about the initiative but that medical, nursing and administrative staff were much less so.

Eighty-five case notes were reviewed as an unselected sample of patients attending a first outpatient appointment in General Medicine, Orthopaedics, Rheumatology or General Surgery. Confirmation of a wish to receive a copy letter was present in 40 cases and all of these patients were asked to complete a questionnaire by post on their satisfaction or otherwise after receiving the copy letter. Some 130 clinical and administrative staff were asked to complete a similar questionnaire. Both patients and staff were also allowed the opportunity in the questionnaire to comment by means of free text.

Staff were generally critical, regarding the initiative as time consuming, bureaucratic and a duplication of time and effort, potentially leading to increased work from telephone calls from patients who had not understood some of the medical terms used in the letter. Patients were correspondingly enthusiastic, with the majority saying that the copy letters helped them to understand their condition or illness and what would happen to them next, as well as being a reminder of what was said during their consultation. Only one patient said that they had noticed a factual error in the letter and all remarked that they could understand the medical terminology used.

The outcomes are so similar to Anna Glasier's findings that I would conclude that the nature of the information being sent to the patient has little bearing on their satisfaction at having received it. The highly personal nature detailing a sexual health consultation appears to be no more or less inhibitory to its formal documentation than a history taken that does not require such intimate detail to be recorded.

Equally striking was the suspicion and uncertainty with which staff approached this issue.

Our personal view is that in terms of this initiative staff appear to have a common hesitant approach but that patients are more sophisticated in their wish to understand their own personal health information than their health worker carers give them credit for.

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References

- 1 Glasier A, Gebbie A, Cowan F. Is it helpful to send copies of clinic letters to women following consultations in sexual health? *J Fam Plann Reprod Health Care* 2005; **31**: 101-102.
- 2 Department of Health. *The NHS Plan*. London, UK: Stationery Office, 2000.

Invisible contraception?

I thought others might be interested to hear a comment passed on to me in my family planning clinic today. My client noticed her friend's Implanon® rod glowing under UV lighting while they were in a nightclub. It didn't put her off having one fitted herself, but maybe we should warn people that their 'invisible' contraceptive method may be seen in these circumstances.

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