HIV and contraception

Thank you for publishing the article on HIV and contraception[1] in the January issue of the Journal. The advice was succinct and helpful. I would just like to add one point. Namely, that all effective methods of contraception will reduce the spread of HIV in a population. This is achieved by reducing the opportunity for mother-to-child transmission during pregnancy.

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Reference
1 Waters L, Barton S. Contraception and HIV: what do we know and what needs to be done? *J Fam Plann Reprod Health Care* 2006; **32**: 10–14.

HIV and contraception

I read with great interest the review by Drs Waters and Barton on contraception and HIV.[1]

The position is clear in HIV-discordant couples (i.e. where one partner is HIV negative) and the authors have rightly concluded that a barrier contraceptive should be combined with another method of contraception when advising these couples. The risk of horizontal transmission with each unprotected act of intercourse is difficult to quantify as it is dependent on a number of factors including stage of HIV infection, response to antiretroviral treatment, and presence of local infection.[2] Moreover, the risk of HIV transmission is significantly increased if either or both the HIV-infected and uninfected partner has another sexually transmitted infection.[3]

As regards HIV concordant couples, there is a possibility of transmission of resistant virus. Therefore these couples should also be strongly encouraged to avoid unprotected intercourse and use a reliable barrier method of contraception in addition to another method of contraception.[2]

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

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1 Waters L, Barton S. Contraception and HIV: what do we know and what needs to be done? *J Fam Plann Reprod Health Care* 2006; **32**: 10–14.
2 Moore AL, Madge S, Johnson MA. HIV and pregnancy. *The Obstetrician and Gynaecologist* 2002; **4**: 197–200.
3 Fleming DT, Wasserheit JN. From epidemiological synergy to public health policy and practice: the contribution of other sexually transmitted diseases to sexual transmission of HIV infection. *Sex Transm Infect* 1999; **75**: 3–17.

Reply

We would like to thank the respondents to our recent article[1] for their comments.

With regard to Qureshi's comments on transmission of resistance virus between sero-concordant couples, we agree that the use of barrier contraception in addition to other methods should be advised. Although, in practice, super-infection with new viral strains is uncommon, independent viral replication in the genital tract means one cannot rely on plasma viral load as a marker of risk for unprotected sexual intercourse. Additional factors such as the presence of concurrent sexually transmitted infections may increase viral shedding and transmission risk.

With regard to Robinson's comments on the association between hormonal contraception and cervical shedding of virus, the evidence is contradictory; we would normally counsel the additional use of barrier contraceptives anyway.

Finally, we agree with Trewinnard that the judicious use of effective contraception will indeed reduce HIV transmission by the mother-to-child transmission route.

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Reference
1 Waters L, Barton S. Contraception and HIV: what do we know and what needs to be done? *J Fam Plann Reprod Health Care* 2006; **32**: 10–14.

Nurse prescribing

As a group of extended nurse prescribers working in the field of contraception and sexual health we are writing to express our concerns about the limitations of not being able to prescribe medicines outside the terms of the product licence.

We are aware that nurse prescribers should not currently prescribe medicines independently for uses outside their licensed indications, and that this decision has been subject to consultation and that the Medicines and Healthcare products Regulatory Agency (MHRA) will be considering responses before putting them to the Committee on Safety of Medicines in the autumn. However, we feel that much prescribing in the field of contraception is off licence, so much so that the FFPRHC Guidance paper on this topic[1] (July 2005) covers 17 pages!

Many summary product characteristics (SPC) sheets are so out of date that the patient information leaflets provide women with information which conflicts with alternative evidence-based sources of patient information such as the fpa (Family planning Association) leaflets. Examples of the impact this has on our practice include the following. We cannot advise a woman to start her pill later than Day 1. We cannot not apply the criteria for being 'reasonably certain' a woman is not pregnant so as to allow >5 days start of the combined oral contraceptive (COC). We cannot advise tri-cycling to prevent withdrawal bleed, reduce menstrual bleeding problems, premenstrual symptoms, or to avoid withdrawal headaches.

We cannot recommend a shortened pill-free interval for women with a true pill failure, or for those on liver enzyme-inducers. Likewise we cannot prescribe two low-dose COCs to give 50 μg for women on liver enzyme-inducers. We cannot increase the doses of emergency hormonal contraception (EHC) for women on liver enzyme-inducers. We cannot offer progestogen-only emergency contraception beyond 72 hours. We cannot offer EHC more than once per cycle. We cannot 'quick start' COC following EHC. We cannot offer a short course of COC/progestogen-only pill for women experiencing initial bleeding problems with an implant.

There are many other situations where best practice would allow our medical colleagues to prescribe out of licence. The above examples of out-of-licence prescribing do not constitute any increased risk to the patient and would all be implemented following careful and detailed assessment and would be in the women's best interest.

Nurse prescribers, working in the area of contraception, want to provide women, of all ages, with optimum care, which is being compromised by outdated SPCs. We hope that the MHRA will apply commonsense and reason to their decisions relating to this important area of health care.

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Reference
1 Faculty of Family Planning and Reproductive Health Care Clinical Effectiveness Unit. FFPRHC Guidance (July 2005). The use of contraception outside the terms of the product licence. *J Fam Plann Reprod Health Care* 2005; **31**: 225–242.

Nurse prescribing

I was disappointed and somewhat dismayed to read the article on 'Nurse prescribing in family planning' in the January 2006 issue of the Journal.[1]

As an extended independent nurse prescriber since 2002, I believe the implementation of the extended formulary has been the single most important factor in promoting the appropriate use of skilled and experienced nurses within the specialty.

Ms Young bemoans the fact that a challenging course of education and assessment is required before nurses can take on this role, and believes that by dint of being a nurse this equates to competence in prescribing. Admittedly, prior to nurse prescribing and the advent of patient group directions (PGDs), many family planning nurses did have the knowledge and skills to assess and treat their patients. However, legitimising this activity has recognised this, and given these experienced nurses the opportunity to use those skills, enhance their practice and, importantly, accept responsibility for their decisions and actions. We no longer require the rubber stamp of the doctors' signatures to endorse our actions (and how many times in the past were nurses frustrated by doctors' refusal to take our advice). Ms Young appears to be advocating a return to the bad old days, when nurses were dependent on the good will of their medical colleagues to 'allow' them to unofficially prescribe, and to carry the can if wrong decisions were made.

Ms Young's frustration at the pharmacist's refusal to comply with her request for her friend is perhaps understandable. However, I suspect most pharmacists would be reluctant to accept a direction from an unknown person over the telephone; although in my experience, most will in fact sell a single packet of contraceptive pills to patients in an emergency. Perhaps, in this case, in view of her friend's 'blinding headaches' this decision was not so wrong.

Family planning has been shown to be one of the most common areas in which nurses prescribe. Already, nurses are able to prescribe the complete range of contraceptives, and the expansion of nurse prescribing this year will allow qualified prescribers to prescribe independently from the whole formulary, for any condition, as long as it is within their scope of competency. Surely this should be seen as a long-awaited advancement for nurses, not in a purely negative and shortsighted way as a cost-cutting measure.

I do applaud Ms Young's beliefs that all specialist nurses need to have the ability to prescribe in their roles, and agree that this is an aspect that could perhaps be addressed in the education of family planning nurses in the future. However, at present, this is not the case.

Prescribing is a complex skill, requiring much more that familiarity with pill packets and knowing the difference between Femodene® and Minulet® (of course, there is none!) Until such as time as prescribing is included within the specialist nurse education programmes, to ensure that good and safe practice is in place, and also to protect nurses and their patients, we cannot assume that all nurses are equally competent and skilled. The current programme for nurse prescribing may not be perfect, but it does, along with continuing professional development, ensure that there is evidence of competence to practice. PGDs are without doubt a 'second best' to prescribing, but they can offer, when properly written, an effective guideline for nurses to issue contraception. We know, of course, that blind adherence to a policy does not 'cover' us against any eventuality. It is following best evidence-based practice that does this, and a good PGD should be doing this.

So, let's look to the future and not get stuck in the past. Nurse prescribing is here to stay, and to expand. I'm sure that eventually all nurses will be prescribers; but in the meantime, let's celebrate the achievements of those nurses who have successfully completed the programme, and support those who wish to. The future of nursing has no place for those who believe that just by doing something for a number of years qualifies them to take on extended roles without any evidence of competence.

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Reference
1 Young F. Nurse prescribing in family planning. *J Fam Plann Reprod Health Care* 2006: **32**: 45–46.

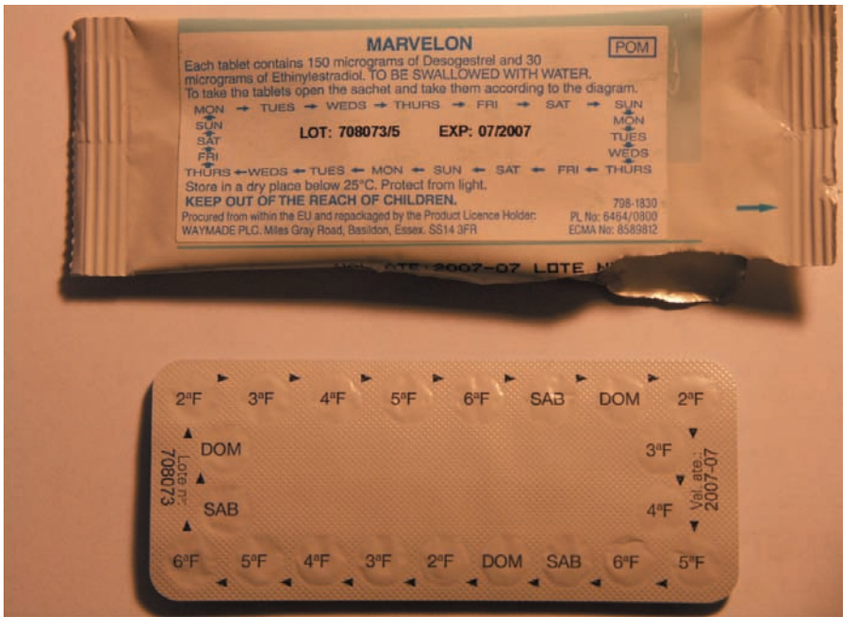

Figure 1 *Example of combined oral contraceptive pill and packaging imported from Spain.*

Imported/foreign COCs

Whilst I was doing a surgery in general practice a few weeks ago, a patient came in for a routine pill check. I went through all the normal questions and history, but when it came to the question "What day do you start your pill packet on?" she hesitated, and then said that she wasn't entirely sure as the pill packets were in Spanish (Figure 1).

Although I feel it is fairly east to follow a strip of pills around a packet, if you miss a pill or make a mistake then you have no idea what day you are on (unless you speak Spanish). Some women find it difficult enough to take a packet of English pills, let alone translate the packet wording as well. I think pharmacists/drug companies should not be allowed to buy cheaper foreign imports, especially with the combined pill which is day-specific, or they should make sure that the wording on each packet is translated into English.

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SUSPICIOUS OF ANYTHING OF A HIDDEN NATURE

JOURNAL READERSHIP SURVEY

We would like to thank the hundreds of readers who took the time to complete and return the readership survey questionnaire included with the January 2006 issue of the Journal. The detailed and wide-ranging comments will be very useful for the Editor and Editorial Team in planning the future direction and development of the Journal. The results are currently being analysed, and a full report of the survey findings will be published in the July issue.

The winner of the prize draw, and the lucky recipient of £100 of Marks and Spencer vouchers, is Dr C Sloan from Cardiff, UK.