

Letters to the editor

Table 1 Duration of intrauterine device/intrauterine system (IUD/IUS) use (in months)

Parameter	IUD/IUS			
	TSafe 380®	Mirena®	NovaT®	Multiload®
Number seen (%)	88 (49.7)	65 (37.1)	11 (6.3)	4 (2.8)
Duration of use	0.5–108	1–84	5–132	0.75–26
Average usage	14.56	21.60	58.64	14.9
Number removed	16	16	6	2
Duration of use at removal	0.5–54	18–84	36–132	0.75–26
Average usage at removal	14.4	44.68	74.16	13.37

Table 2 shows the year of removal. Eleven (27.5%) were removed in the first year of use, of which nine were TSafe 380® IUDs. Three of these had extruded and four were removed for bleeding. Eight (20%) were removed in the second year, of which three TSafe 380 IUDs were removed to facilitate pregnancy. More than 50% of the IUS removed were after 5 years. There were no IUS/IUD-related pregnancies.

Table 2 Removal of intrauterine device/intrauterine system (IUD/IUS) (in year)

IUD/IUS	Year								
	Y1	Y2	Y3	Y4	Y5	Y6	Y7	Y8	>Y9
TSafe 380®	9	4	0	1	2	0	0	0	0
Mirena®	1	4	1	1	8	0	1	0	0
Multiload®	1	0	1	0	0	0	0	0	0
NovaT®	0	0	1	1	1	0	1	1	1

In the series from the Family Planning and Reproductive Health Research Network,² 238 clients had their IUS removed before 5 years for bleeding, medical and other reasons. In our series of IUS there were no removals for bleeding; the most common reason for removal being that the device had reached its recommended duration of use or contraception was no longer required.

Only 42% of all device removals were for problems related to the device itself. Most removals in the first year were of TSafe 380 IUDs. Sivin *et al.*³ showed the CuT380A device to have a removal rate of 23.3/100 users for bleeding and an expulsion rate of 7.4/100 users at 5 years. Cox *et al.*² speculated that the expulsion rate may be due to the increased copper content or the design of the device. However, could expulsion of the device also be related to the skill of the operator or poor client selection and pre-insertion counselling?

We agree with Cox *et al.*² that counselling before fitting the IUS is important. Likewise, careful patient selection, addressing the concerns of women and their beliefs,⁴ and improving communication during consultations⁵ helps with compliance in the use of IUDs.

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- 2 Cox M, Blacksell S. Clinical performance of the levonorgestrel intrauterine system in routine use by the UK Family Planning and Reproductive Health Research Network: 5 year report. *J Fam Plann Reprod Health Care* 2002; **28**: 73–77.
- 3 Sivin I, el Mahgoub S, McCarthy T, Mishell DR Jr, Shoupe D, Alvarez F, *et al.* Long-term contraception with the levonorgestrel 20 mcg/day (LNg-20) and Copper T380Ag intrauterine devices: a five-year randomised study. *Contraception* 1990; **42**: 361–378.
- 4 Asker C, Stokes-Lampard H, Beavan J, Wilson S. What is it about intrauterine devices that women find unacceptable? Factors that make women non-users: a qualitative study. *J Fam Plann Reprod Health Care* 2006; **32**: 89–94.
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Training GPs to fit IUDs/IUS

I was delighted to read the article on training general practitioners (GPs) to fit intrauterine devices/intrauterine systems (IUDs/IUSs) by Deborah J Lee in the July 2007 issue of the Journal.¹ Dr Lee has been very proactive in developing alternatives to the traditional format for this specialised training. Having heard about her work I too have been developing a 'peripatetic' system for training clinicians, based mainly on Dr Lee's ideas. There are exciting times ahead; it is possible that practice-based commissioning will lead to a renaissance in the provision of services in the community by primary care. I have some comments:

- I have been training both doctors and nurses – particularly with Implanon® insertion and removal. Long-acting reversible contraception (LARC) provision by suitably trained nurses should be available for all women.
- There is a cohort of older GPs who have great skill and many years experience in IUD fitting who do not have any certificates or Letters of Competence (LoC). The National Enhanced Service Contract for primary care accepts their experience under 'Grandfather' rules. I have worked with Dr Mohammed Edris to develop a system of revalidation, which involves visiting the practice and observing the clinician fit at least three devices. This visit is also used as an updating and teaching session, reviewing issues such as sterilisation of equipment and current issues. My visits have been welcomed by my GP colleagues, who often work in isolated settings. The learning is mutual! I suggest that PCTs should consider incorporating some sort of a system for all providers with whom they place contracts for IUS/IUD/Implanon services.
- By training practitioners who are in established practice, I know that they will develop their services because they are responding to the needs of their locality. This is different to doctors in training completing another LoC because it will look good on their CV.
- I also do a regular session in a community family planning clinic, and find that the pressure on appointments for LARC makes unhurried training difficult. There is increasing demand for these services when as we know there is little financial investment in community sexual health services at present.
- My colleagues in training have been supported by drug company financial support. Of course Organon has a motive to ensure that practitioners who fit and remove its implants are suitably trained, as this should reduce litigation. I see this as mutually beneficial. Primary Care Trusts (PCTs) have become very wary of involving drug companies in any form of sponsorship. There is no money specifically available for training in general practice as this is included in the 'Global Sum'. I am

concerned that nurses in particular could lose the opportunity to train, as their GP employers may not see cost benefits. I now simply charge clinicians per IUD fitted – this sum is slightly lower than the amount the PCT pays per fit. By training and accrediting, the practice is greatly enhancing its earning potential. I only train to the Faculty LoC standard and encourage revalidation.

- My only concern is the issue of indemnity, which was not discussed by Dr Lee. As a visiting clinician undertaking a procedure on a patient registered with another doctor, I assume my liability follows me wherever I go, but my insurance company may need to consider any new risks.
- The National Institute for Health and Clinical Excellence (NICE) guidelines on menorrhagia suggest that women should be offered the IUS.² This will not be a contraceptive service. Along with the LARC guidelines, I conclude there will be many women seeking IUS/IUDs/implants. The vision of a locally accessible service provided by well-trained clinicians will need lots more training in a variety of settings. There are opportunities for trainers to set up 'provider' services that will train and accredit, and which could be profitable.

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Training for the LoC IUT

Is it time to alter the criteria for this qualification?

At the moment the training requirement for the Faculty of Family Planning and Reproductive Health Care Letter of Competence in Intrauterine Techniques (LoC IUT) is that the trainee should fit at least *two different* currently available devices. I have recently had one of my trainees refused her certification because she had only fitted Mirena® intrauterine systems (IUS) as there were no patients who wished to have a copper intrauterine device (IUD).

I think that the criteria need to be changed. There is now very little demand for copper IUDs in general practice. When patients are given the choice between a device which is not 100% effective and is likely to make their periods heavier, more prolonged and more painful, and one which is much more effective and will make their periods lighter and less painful, it is not surprising that they will mainly choose the Mirena. I was at a lecture last month given by a well-respected family planning instructing doctor. He was saying that copper IUDs were yesterday's technology and that we should be fitting Mirenas in everyone. [I was defending the copper IUD!] In my own general practice in the past year I have fitted 55 IUDs and only three of them were copper IUDs. Even in my family planning clinic, only 18/60 were copper IUDs.

The Faculty has to recognise the reality of the situation. Most general practitioners (GPs) will only fit Mirenas. If we refuse to accredit individuals unless they have done a copper IUD insertion then how are they going to obtain accreditation? Will we have to force patients to have copper IUDs fitted against their will? It is increasingly difficult for trainees to obtain their IUD training experience as there are fewer trainers able to do it and reduced clinics in which to be trained. There is going to be