a major problem when my generation of GPs retires and IUD fitters will not be replaced. Surely the role of the Faculty should be to increase and encourage training, rather than to stick to rigid and outdated requirements?

The present LoC IUT allows a doctor to fit any device once they have completed seven insertions. This means that they could fit six Mirenas and one Flexi-T® and then be deemed competent to fit a Nova T380® or a TT380 Slimline®. It does not, quite reasonably, demand that they fit all available devices. It requires doctors to practise within their field of competence and to refer on any procedure at which they do not feel competent. The Faculty CD-ROM on intrauterine techniques is extremely useful and I am sure that most doctors would refer to that before fitting a device with which they were not too familiar. Most of us trained ourselves by simply reading the instructions on the pack! I cannot see why there should still be a requirement for two different devices to be fitted. If the rules are not amended, there is going to be a severe lack of doctors being trained to fit IUDs. This only serves to diminish even more the patient's right to choose.

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## Menstrual migraine

I read with interest Dr Anne MacGregor's review on menstrual migraine in the January 2007 issue of the Journal.[1]

On page 44, under the title 'Perimenstrual oestrogen supplements', Dr MacGregor explained when such supplements are not recommended. The use of perimenstrual oestrogen such as transdermal oestrogen (100 µg daily) in the prophylaxis of menstrual migraine is of concern because of the apparent synergism between migraine and contraceptive oestrogen as risk factors for stroke.[2] I think other forms of oestrogen that are not a component of a contraceptive method are not free of such risks. The Members' Enquiry Response[2] and myself were surprised by the guidance of BASH[3] and PRODIGY[4] on the use of transdermal oestrogen for prevention of menstrual migraine. I will not recommend it in the prevention of menstrual migraine, especially if it is associated with further risk factors such as the presence of aura. The absolute risk of ischaemic stroke in those women is fortunately very small but prevention is the preferred option.

In one patient with menstrual migraine, I used a non-steroidal anti-inflammatory drug, as a prophylactic treatment, that delayed the migraine to other times of the cycle. The patient is currently well controlled on gabapentin.

On page 44, under the title 'Continuous combined hormonal contraceptives', other conditions related to migraine were not stated, when such therapy should not be used. Combined oral contraception is absolutely contraindicated in women with migraine without aura if they have more than one additional risk factors for stroke such as age over 35 years, smoker or obesity.

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## Reply

I am grateful to Dr Al-Hassan for giving me the opportunity to clarify the safety of oestrogen supplements for the prevention of menstrual migraine.

As mentioned in the review, compared to non-menstrual attacks, menstrual migraines are more severe, last longer, are less responsive to symptomatic treatment and more likely to relapse.[1] Prophylaxis for menstrual migraine is indicated when acute therapy does not adequately control symptoms. The rationale for short-term perimenstrual prophylaxis is to target intervention to the time of need, limiting potential side effects of medication to a few days rather than throughout the cycle. As Dr Al-Hassan emphasises, it is important that such treatments are safe.

Regarding the concern about migraine aura, menstrual migraine is, by definition, without aura so the issue of using oestrogen supplements for migraine with aura should not apply.[2] I address the risk of oestrogen replacement in women with migraine with aura in a review in this issue of the journal.[3]

Also important is the different pathophysiology of migraine with aura compared to migraine without aura, with respect to oestrogen. Although high doses of oestrogen are often associated with the development of aura, withdrawal of oestrogen precipitates migraine without aura.[4] This is the rationale for using oestrogen supplements to bridge the interval between the luteal phase oestrogen decline and the follicular phase rise. The recommended dose of oestrogen, 100 µg patches provide plasma levels of oestrogen of the order of 382 ± 232 pmol/l (i.e. maintaining luteal phase levels).[5] On this basis, the risk of ischaemic stroke associated with perimenstrual supplements should be no greater than the risk associated with the normal menstrual cycle.

In contrast to physiological doses of natural oestrogens, combined hormonal contraceptives (CHCs) contain potent synthetic oestrogens in order to suppress ovulation. Even when taken by healthy women, CHCs are associated with a small but measurable increased risk of ischaemic stroke. This risk has not been shown for natural oestrogens used by perimenopausal women.[6] It is unclear why, in their evidence-based response, the Clinical Effectiveness Unit have extrapolated data regarding increased risk of ischaemic stroke in women with migraine associated with use of CHCs to imply that the same risk is associated with use of physiological doses of natural oestrogens.[7] In addition, since there is evidence that risk of stroke is associated with frequency of migraine, one could speculate that preventing attacks might be associated with reduced risk.[8]

On that note, Dr Al-Hassan remarks on delayed migraine following perimenstrual prophylaxis with non-steroidal anti-inflammatory drugs. This has also been shown with perimenstrual prophylaxis with oestrogen and with naratriptan.[9,10] From a clinical perspective, although this can be a problem for individual women, it is not a problem for all. It is usually resolved by extending the duration of perimenstrual prophylaxis and tapering the dose or, as Dr Al-Hassan correctly notes, by continuous prophylaxis.

Finally, prohibiting use of CHCs in women with migraine without aura who have more than one additional risk factor for stroke has been the standard recommendation for a number of years and was based on the evidence available at the time.[11] In light of new research, there is increasing evidence to suggest that the risk of ischaemic stroke associated with migraine without aura is not significant.[12] Hence, my recommendation is that there is no reason to restrict use of CHCs by healthy, non-smoking women over the age of 35 years who have migraine without aura.

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## Review of abortion laws

Ann Furedi's[1] is the most recent voice to call for a review of the 1967 Abortion Act,[2] seeking to set aside some of the checks and balances, which she believes are restrictive. Others, however, feel the laws are too liberal and should be tightened.[3] Whatever might have been the driving force behind the Act, it was well crafted with the interest of the woman uppermost and remains as relevant today despite its age of 40 years. It has sufficient checks and balances in place to allow women access to terminate unwanted pregnancies, by trained people who want to provide the service in regulated premises to ensure safety and avoid morbidity. The Act does not need amending either one way or the other. Advances in medicine are occurring all the time and some of these have been incorporated into providing abortions without a need to amend the Abortion Act (e.g. nurse-led medical abortions).

There is concern, however, that numbers of terminated pregnancies continue to rise[4] and therein lies the problem, the solution of which is not to amend the abortion laws. Most women wanting to terminate pregnancies became pregnant as a result of non-use or poor use of contraception.[5] More effort needs to be put into preventing unwanted pregnancies in the first place by effective and reliable contraception. If there were no unwanted pregnancies there would be no requests for termination of pregnancies. The National Institute for Health and Clinical Excellence (NICE) has recommended long-acting reversible contraceptives (LARC) as the contraceptives of choice,[6] yet these remain poorly promoted and not readily available to women as many general practice surgeries do not provide the full range of these methods.[7]

Furedi[1] attempts to draw parallels between the rights of competent pregnant women to refuse

Caesarean section and the competent pregnant women to have abortions. While the two scenarios may appear similar, they are in fact very different and different rules apply. While a competent pregnant woman can always expect to have her refusal of the offer of a Caesarean section respected, a competent pregnant woman cannot at all times expect to have her request for a termination of pregnancy to be honoured.

The abortion law as it stands now is robust enough and does not need any amendments. The delivery of abortion services may be poor in some areas. The solution in such areas is to implement guidelines published by the Royal College of Obstetricians and Gynaecologists (RCOG),[8] which should ensure a high-quality service nationwide, rather than seek to amend the Abortion Act.

Abortion is an emotive issue for all concerned. We should direct our energies towards reducing the numbers of women seeking abortions by implementing the NICE guidelines on LARC nationwide. This approach will yield better results than an amendment of the Abortion Act.

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## Reply

Umo Essen is right to argue that the Abortion Act 1967 was 'well crafted', and my earlier article concurred that that it has "served women, and their families reasonably well".[1] It is also true that a liberal interpretation of the law has enabled safe, legal abortion services to develop far more effectively in Britain than in many other countries with legislation that appears less restrictive. However, it is complacent to conclude that a review of the law is not needed and wrong to assert that it does not require change.

There are several areas where the law impedes good clinical practice.

The Royal College of Obstetricians and Gynaecologists guidelines state that women should be able to access a termination as early as possible, because the earlier in pregnancy an abortion is performed, the lower the risk of complications. Ideally, the guidelines state, the abortion should be able to take place within 7 days of the decision being agreed and with a minimum standard of the procedure within 2 weeks.[2] The legal requirement that two registered medical practitioners certify that a woman meets the legal grounds for abortion frustrates this by creating the potential for unnecessary delay.

Despite an acknowledged shortage of doctors willing to carry out abortions,[3] nurses and midwives are prevented from carrying out procedures, such as manual vacuum aspiration, which are performed by colleagues with equivalent qualifications in other countries, because the Abortion Act specifies that abortion is only lawful when carried out by a "registered medical practitioner", which is interpreted as a General Medical Council registered doctor only. This remains the view of the Department of Health despite challenges that the law could be interpreted differently.[4]

Women undergoing early medical abortion with mifepristone and misoprostol are required to make additional, unnecessary clinic visits because both medications are regarded as abortifacient and so must be administered in a hospital or licensed premises. In other countries, such as the USA, it is possible for women to administer the misoprostol herself at home, thus reducing the cost and inconvenience of the procedure.[5]

Doctors' ability to interpret statutory ground C (section 1(1)(a)) of the Act liberally to allow the abortion of unwanted pregnancies has allowed the law to meet the needs of modern society. But, this openness to interpretation means that women can never be confident that their abortion request will be viewed sympathetically. Often, women feel they need to exaggerate their distress and to pretend that they will be psychologically damaged by their pregnancy, while their doctors pretend to believe them. This is a charade that demeans them both.

Women living in Northern Ireland suffer the additional burden of being required to travel to Britain for treatment as this part of the UK is excluded from the provisions of the existing Abortion Act.

It would be far better to have a law that specifically allows a woman to end a pregnancy that is unwanted without further justification, and permits abortions to be carried out by persons, and in premises, that are able to provide adequate care and support. In short, abortion should be available to women who request it, and regulated by the same principles and standards as other clinical procedures.

We can all agree tha t it would be better if unwanted pregnancies were prevented, and that increased use of long-acting reversible methods of contraception may contribute to this end. However, these methods are not suitable for, or acceptable to, all women. The rising number of abortions demonstrates that abortion is necessary as a backup to other methods of birth control, and this is likely to remain the case in a society that has a liberal attitude to sexual activity and values planned parenthood. Our experience is that the social stigma of abortion is lessening in pragmatic response to this.

My earlier commentary argued that women, and their doctors, deserve "a flexible, fit-for-purpose law accepting that restrictions on abortion should be solely to protect health". The current review of the medical and scientific aspects of abortion by the House of Commons Science and Technology Select Committee and the forthcoming discussion of the Human Tissue and Embryos (draft) Bill provide an opportunity for Members of Parliament to align our abortion law with modern thinking.

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## Remember 1967? We do…

I read the comment from the Journal's Consumer Correspondent in the July issue with great interest. I was 2 years old when the Abortion Act was passed and I have been actively pro-choice since I was 14 years old. It's very interesting to note that the respondents to Ms Quilliam's questions have changed their views so much in the intervening 40 years.[1] During that time it seems we have lost the ability to remember women dying from unsafe and illegal abortions in the UK, so the necessity for the law seems less urgent. As Quilliam notes, there still needs to be much better access to sex education and contraceptive services, particularly for young people. The fact the UK leads Europe in teenage pregnancies suggests that young women are not all turning to abortion as the solution to their unplanned pregnancies. Unfortunately, young people are amongst the most anti-choice because they have unrealistic expectations of parenthood. If frank information about sexual health and family planning could be better promoted for young people we could start to genuinely turn this situation around.

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## LETTERS TO THE EDITOR

Letters to the Editor are welcome and generally should not exceed 600 words or cite more than five references. For comments on material published in the most recent issue of the Journal, correspondence should be received within 4 weeks of dispatch of that issue to be in time for inclusion in the next issue. When submitting letters correspondents should include their job title, a maximum of two qualifications and their address(es). A statement on competing interests should also be submitted for all letters. Letters may be submitted to the Editor or the Journal Editorial Office, Faculty of Family Planning and Reproductive Health Care, 27 Sussex Place, Regent's Park, London NW1 4RG, UK. E-mail: journal@ffprhc.org.uk.