

Chlamydia testing in the UK

The statement in the commentary article by Skidmore *et al.*¹ that "in the UK, the Department of Health has provided funding for all National Health Service laboratories to adopt [nucleic acid amplification] tests", for the detection of *Chlamydia trachomatis*, seems to be based on treating the terms England and UK as synonymous. While that might be an understandable mistake, it is still a mistake.

In 2003, the Department of Health in England provided £8 000 000 to support laboratories to change from the inaccurate but cheap enzyme-linked immunoassay tests (ELISAs) for *C. trachomatis* to the accurate but expensive nucleic acid amplification tests (NAATs).² Four years later, the Chief Medical Officer (CMO) in Wales has taken a similar view that testing platforms for the detection of genital *C. trachomatis* other than NAATs are suboptimal. Unfortunately, although the CMO estimates that it will only cost £150 000 to extend the use of NAATs across the whole of Wales and states that "service commissioners and providers would be highly vulnerable to criticism if what is now the recognised optimal testing method was not used", I do not think that any funding has been provided to the laboratories in Wales.³

Here in Mid Wales we are still using an ELISA to detect, as the CMO estimates, 70% of female and 54% of male genital *C. trachomatis* infection³ and, as I write this letter, we have but 7 weeks to comply with the CMO's expectation that all individuals tested for chlamydia infection in Wales will be offered the NAAT by 1 December 2007.³

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Implanon® failure and antiretroviral therapy

We read the case report by Matiluko *et al.*¹ in the October 2007 issue of the *Journal* with interest. Efavirenz, a non-nucleoside reverse transcriptase inhibitor (NNRTI), is known to have complex interactions with cytochrome P450 enzymes, being both an inhibitor and an inducer of this system. Characteristically it has been the protease inhibitor (PI) class of antiretroviral therapy (ART) that has been associated with contraceptive failures. Nonetheless, both commercially available NNRTIs (efavirenz and nevirapine) are associated with reduced *in vivo* levels of ethinylestradiol and progestogens.² In the reported case, the patient was receiving an NNRTI-based regime and had begun having regular menstrual cycles after almost 2 years of amenorrhoea following Implanon® insertion. There is no evidence for the use of Implanon in HIV-positive patients, specifically those receiving ART, although results are awaited from a USA study which has fully recruited and is looking at the impact of lopinavir/ritonavir (Kaletra®, a PI used as ART) on Implanon efficacy (Laura Waters, personal communication,

2007). In our personal opinion, HIV-infected patients who wish to continue using Implanon after appropriate counselling regarding risks and benefits should be advised not only to also use a concomitant barrier method, but also to consider earlier replacement (e.g. after 2 years if regular menses commence following a period of amenorrhoea). This would be consistent with the advice given currently to women weighing more than 70 kg, for example.³ Whilst we cannot deny that Implanon is currently not an ideal contraceptive method in terms of pharmacokinetics or STI prevention in our HIV-positive population, there remain significant advantages to the method in HIV-positive women. It is a method over which women have control and which is long acting, thus decreasing the time spent by women attending health care services. It is also a method that may be used by women needing to conceal contraception from their male partners.

It is difficult to say in the case presented if the drug interactions were truly to blame for Implanon failure. In the absence of good pharmacokinetic data or studies regarding the combined use of ART and Implanon it would seem best to continue to recommend other methods however. With appropriate counselling it may also be sensible to advise women wishing to continue with this method to consider earlier Implanon replacement, especially if regular menstrual cycles commence before the normal 3-year replacement date.

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Reply

We thank Drs Barber and Waters for their interest in, and letter about, our recent case report.¹ At no point in our case report did we unequivocally state that Implanon® failure was due to the patient's antiretroviral therapy (ART). We only hypothesised on the connection between the ART and the early failure of Implanon as the patient was not on any other medication except for Becotide®, which to our knowledge has no liver enzyme-inducing effect.

The case was reported to highlight the potential reduction in the effective duration of contraceptive efficacy of Implanon in the presence of concomitant administration of drugs with potential for liver enzyme induction (i.e. ART).

We would, however, agree with Drs Barber and Waters that pending studies on the use of Implanon in HIV-positive patients on ART, its use should be with appropriate counselling regarding risks and benefits and concomitant use of barrier method for obvious reasons.

Although the patient in the reported case was amenorrhoeic for almost 2 years, we would suggest that consideration for earlier replacement or alternative contraception should be sought at the

nearest family planning clinic as soon as periods are resumed after any period of amenorrhoea following insertion, since resumption of regular periods following post-insertion amenorrhoea may vary from one individual to another based on many other factors such as weight, use of other medications, and so on.

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Difficult IUD insertions

After approximately 25 years' experience of fitting intrauterine devices (IUDs) in general practice, I have of late found myself pondering why slowly the process seems to become increasingly difficult. Rather than becoming easier the more experience I gain, IUD fits seem to become more problematic. Surely not what one would expect?

And then the penny dropped. Back in the 1980s, the standard IUD patient would be in her 30s with two or three vaginal deliveries behind her who had lost all her inhibitions about gynaecological procedures years before. Today's IUD patient may have had perhaps one baby by Caesarean section, or be nulliparous, in her early 40s and requesting a Mirena® for menstrual problems; neither individual will be the easiest to fit with an IUD and neither will be well prepared for the indignity and discomfort that inevitably accompanies the procedure. Would other experienced practitioners concur with this, or am I just making excuses?

Because if I'm not making excuses, we need better means of handling the pain of an IUD insertion, dilators, sounds and progestogen devices that are suitable for nullips, tenaculae that cause minimal pain, and so on. And concern for the trainees who have to learn in this environment.

All sensible comments are very welcome.

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Training for the LoC IUT

As a practising instructing doctor, I disagree with the arguments put forward by Dr Devonald in her letter in the October 2007 issue of this journal¹ for considering altering the criteria for this qualification.

Within our practice we actively promote the use of intrauterine devices (IUDs) and the intrauterine system (IUS) as long-acting reversible contraceptive (LARC) methods in suitable women. All women requesting an intrauterine method are seen at an initial counselling and assessment session to discuss their contraceptive needs and they are informed about all their long-term options. We find that this allows women to be informed users and improves compliance with their chosen method.

In 2005–2006, I fitted 162 copper IUDs, which were mainly the 'gold standard' TCu380A (T-Safe380A®) and 57 Mirena® devices. Last year (i.e. in 2006–2007) this changed to 181 IUDs and 43 Mirenas. Of these, one woman had to change to Mirena due to heavy periods but the rest have reported no problems with pain or bleeding. Conversely, one Mirena had to be removed within a week as the woman did not like the idea of having a hormonal coil. She had originally been counselled by her own general practitioner (GP).