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* infection[3] 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]

Peter Watson, DFFP, FRCP
Consultant in Genitourinary Medicine, Ceredigion and Mid Wales NHS Trust, Bronglais General Hospital, Aberystwyth, UK
E-mail: peter.watson@ceredigion-tr.wales.nhs.uk

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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.

Tristan J Barber, MRCP, DFFP
Specialist Registrar in GUM/HIV, Chelsea and Westminster NHS Foundation Trust, London, UK
E-mail: tristan.barber@chelwest.nhs.uk

Laura Waters, MRCP, DFFP
Locum Consultant in GUM/HIV, Imperial College Healthcare NHS Trust, St Mary's Campus, London, UK

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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.

A A Matiluko, MBBS, MRCOG
Senior Registrar, Department of Obstetrics and Gynaecology, North Hants Hospital, Basingstoke, UK
E-mail: tbs8996@matil.freeserve.co.uk

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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.

Isabel B Draper, MRCGP, FFFP
General Practitioner, Whitehall Medical Practice, Rugby, UK
E-mail: IBD@doctors.org.uk

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 journal[1] 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).

I agree with Dr Devonald's comment that most GPs will only fit Mirenas. In my opinion, this is contrary to patient choice and good practice. In the area where I work, women are directly asking for a non-hormonal LARC, or after discussions find irregular bleeding patterns or amenorrhoea with Mirena unacceptable. Also, an IUD may be needed for emergency contraception purposes. Therefore, I believe that the copper IUD is a very useful method in good hands and there is enough evidence around to prove this.

In the light of the above comments, I would therefore argue that there is no need to consider changing the criteria for the Letter of Competence in Intrauterine Techniques (LoC IUT) training. However, more importantly, our efforts should focus on improving timely access to high-quality training for LoC IUT and Letter of Competence in Subdermal Contraceptive Implant Techniques (LoC SDI). I have been made aware by current trainees that there are some real issues with arranging suitable practical training sessions. There can be a wait for up to a year in some areas for training. Some GP registrars are no longer planning to undertake LoCs as they feel that there is a lot to do during their training year and they cannot spare the time, particularly if the training clinic is located miles away. Some of the trainees are also unable to obtain study leave or find locums if they wish to undertake LoCs. This is more worrying for the speciality as a whole and obviously limits patients' choice in the long term. I wonder, therefore, whether there is any possibility of including DFSRH (formerly DFFP) and LoC training as it relates to IUDs/implants as a core skill during the obstetrics and gynaecology placement?

Farzana Siddiqui, FRCOG, MFFP
Consultant in Contraception and Sexual Health, Oldham Primary Care Trust, Failsworth Primary Care Centre, Oldham, UK.
E-mail: farzana.siddiqui@nhs.net

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Missed opportunities in discussing LARC

We conducted a study on the feasibility of self-completed history questionnaires in a central London community contraceptive clinic in October 2006. Participants were established users of combined hormonal contraception (CHC, which includes the pill and the patch) requesting repeat supplies.[1] Along with questions on personal and family history to identify risk factors, we included a question: "Would you like to discuss other methods of contraception such as long-acting methods which you do not have to remember to take each day?" Twenty-one percent (68/328) of women replied 'Yes' to this question. This is an important finding, considering the fact that these women were already well established on their CHC.

Given this response, we suggest that when a woman comes for repeat supplies of her CHC, it should be taken as an opportunity to discuss long-acting reversible contraception (LARC) methods. Choice of contraception is essential to meet diverse user needs, and preferences may change with the user's stage in life. Only by offering choice will the maximum number of women be protected and will the uptake of LARC increase. If health professionals make assumptions that a woman's current method of contraception is the best and most acceptable to her, they could be missing opportunities for discussing other methods.

National Institute for Health and Clinical Excellence (NICE) guidance recommends that all women requiring contraception should be given information about, and offered a choice of, all methods, including LARC.[2] Little is known about the extent to which women requesting contraception are actually offered these methods. In general practice the availability of LARC methods is often limited, which is also likely to affect uptake.[3]

LARC offers definite cost benefits to health services, with all methods being more cost-effective than the combined oral contraceptive pill even at 1 year of use.[2] In addition, these methods offer non-contraceptive health benefits, such as the levonorgestrel intrauterine system providing treatment for menorrhagia.[2]

Non-use of contraception places a far heavier financial burden on society and public funds.[4] In the UK, an estimated 50% of pregnancies are unplanned and approximately one-fifth of conceptions end in legal abortions.[3] An increased uptake of LARC could help to reduce unintended pregnancy.

We support the view that improving access to the full range of contraceptive methods and increasing nationally accredited training for all contraception providers is required.[3] The potential benefits of LARC methods over CHC can actually be realised if this is applied as an auditable standard for all clinicians involved in contraceptive care.

Jagruti S Doshi, MRCOG, DFFP
Subspecialty Trainee in Sexual and Reproductive Healthcare, Margaret Pyke Centre, London, UK.
E-mail: jsdoshi@doctors.org.uk

Rebecca S French, MSc
Senior Research Fellow, Centre for Sexual Health and HIV Research, Department of Primary Care and Population Sciences, Margaret Pyke Centre, London, UK

Christopher L Wilkinson, MBBS, FFFP
Consultant, Margaret Pyke Centre and Mortimer Market Centre, London, UK

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FACULTY AWARDS

The Faculty of Sexual and Reproductive Healthcare has available a number of annual awards for which applications are invited from Faculty members and non-members as listed below. Details of the individual awards, together with an application form and/or guidelines on how to apply and any eligibility criteria, may be found on the Faculty website at **www.fsrh.org**.

Margaret Jackson Prize Essay

Award: Three prizes awarded annually for the best essays on a topic related to contraceptive and sexual health care. The first prize is £300, with £100 each for the two runners-up.
Eligibility: Individuals (undergraduate medical students) **Closing date:** 24 March annually

The David Bromham Annual Memorial Award

Award: Prize awarded for a piece of work which through inspiration, innovation or energy has furthered the practice of sexual and reproductive health care in any way and any setting.
Eligibility: Individuals (Faculty members) or teams **Closing date:** 7 April annually

International Travelling Scholarship of the Faculty

Award: Scholarship up to the value of £2000 to fund travel abroad to visit international colleagues, services, research or educational establishments to learn about some aspect of sexual or reproductive health care.
Eligibility: Individuals (Faculty members) **Closing date:** 7 April annually

The 4-0-8 Sheffield Fund

Award: Approximately £1000 will be allocated every 3 months, either as a single award or divided between the successful applicants, for the purpose of funding training for health care professionals who have limited funding for attending training meetings.
Eligibility: Individuals (Faculty members/non-members) **Closing date:** See website for details