UK centres for Implanon® removal

Mea culpa – when writing the article on the UK provision for removal of non-palpable contraceptive implants[1] I forgot to include Dr Martyn Walling in Table 1. Martyn has the UK's greatest experience in removing deep implants and is based at Lincolnshire PCT, Orchard House, Greyleas, Sleaford NG34 8PP, UK. He is very happy to accept written referrals sent to this address.

Martyn has also been working as an independent practitioner, travelling the length and breadth of the UK, training doctors to locate and remove non-palpable implants.

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Editor's note
An updated version of Table 1 in Dr Mansour' article referred to above, which lists the UK referral sites for removal of deep/non-palpable contraceptive implants, appears on page 85 of this issue of the Journal.

Contraceptive failure with Depo-Provera®

I have a concern regarding the recent case report where a 28-year-old woman was given a subsequent (second) injection of Depo-Provera® by a practice nurse when she attended after 13 weeks, and when no precautions were advised, nor documentation done. The patient subsequently again reported with a positive pregnancy test and opted for a termination of pregnancy.[1]

My personal feeling is that although by and large consultation times are often too short for practising doctors to cover all aspects of counselling at all times, when a patient is using a contraceptive method outside the terms of the product licence, to ensure that optimal service is offered and also in view of the remote possibility of litigation following failure of the method, it should be mandatory for the practising doctor to also get involved and appropriately counsel, and to adequately document such an episode.[2,3]

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Reviewing the National Sexual Health and HIV Strategy

In response to the article entitled 'Reviewing the National Sexual Health and HIV Strategy' published in this Journal,[1] I would like to endorse the authors' comments with regard to the lack of standardised training for nurses in reproductive and sexual health care. As an educator in a Higher Education Institute (HEI), with experience of contributing to developing national education and training initiatives, I would like to express similar frustrations with the lack of national standards in sexual health training for nurses. With the increasing pressures on services, HEIs must develop innovative solutions to meet the sexual health education and training needs of nurses. Providing academic accreditation for such a national 'e-learning' course could be one solution to meeting the standards in reproductive and sexual health service delivery.

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Reference
1 Mann S, Wilkinson C. Reviewing the National Sexual Health and HIV Strategy. *J Fam Plann Reprod Health Care* 2008; **34**: 211–212.

Reviewing the National Sexual Health and HIV Strategy

I write in response to the article entitled 'Reviewing the National Sexual Health and HIV Strategy', published in the October 2008 issue of this Journal.[1] I would like to applaud the authors' comments within this article relating to the lack of standardised training for nurses in reproductive and sexual health care. Since the demise of the National Boards, nurses and their employers have been left in a very unhealthy void as they are unable, with confidence, to ensure that either the training they are receiving, or the training that has been undertaken, is robust enough to ensure the provision of consistent, effective and evidence-based advice to clients. At least when a nurse presented with the (E)NB course certificates you knew what you were getting! I am sure that many other nurses, and employers of nurses, would be overjoyed to see the new DFSRH online learning programme being able to be accessed and accredited for nurses as the new 'gold standard' for training in this area.

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Reference
1 Mann S, Wilkinson C. Reviewing the National Sexual Health and HIV Strategy. *J Fam Plann Reprod Health Care* 2008; **34**: 211–212.

Sexual health of South Asians in the UK

I was interested to read the comprehensive review article by Griffiths *et al*.[1] and the discussion on sexual knowledge and behaviour, contraceptive behaviour, and sexually transmitted infections (STIs) and HIV in the South Asian population. There is very scant if any information on ethnicity and abortions. Though abortion statistics have been available from 1968 from the Registrar General and from 1974 from the Office for Population Censuses and Surveys OPCS/Office of National Statistics (ONS), it was not until 2005 that ethnicity was included in data collection. Our unpublished data in Waltham Forest (for 2006) show that of a total of 1257 abortions, >50% of abortion requests were from Asian, black and mixed-race women, though only 35% of women in our population are categorised as mixed-race, Asian or black. Some 31% of abortions were in white British, Irish and other white women compared to 24% in black and 19% in Asian women. Being a black, Asian or mixed-race woman emerged as an important risk factor for induced abortions. However, we did not study other ethno-cultural variables such as social class, deprivation and educational status.

Chlamydia screening has not been discussed by the authors. In 2007, the English National Chlamydia Screening Programme (NCSP) performed over 270 000 screens in under-25-year-olds and the overall positivity rate was 9%. The positivity rate in young Asians was less than 5%.[2]

Again, there is little if any information on ethnicity and teenage births. However, in a recent study of teenage births to ethnic minority women, Pakistani and Bangladeshi women were much more likely to have been teenage mothers compared to white women, but Indian women were below the national average.[3]

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Reply

We thank Dr Sunanda Gupta for comments relating to our review of the sexual and reproductive health of South Asians in the UK.[1] We agree there is a paucity of detailed data on ethnicity and abortion and on ethnicity and teenage births. In 2002, the abortion notification form (HSA4) was revised to allow for the recording of ethnicity, as self-reported by the women involved. This information was not previously recorded. In 2007, of the 198 499 legal abortions that were recorded, 75% of women reported being white, 11% black or black British, and 8% Asian or Asian British. Interestingly, the percentage of previous abortions (where the woman has had one or more previous abortions in addition to the one recorded for 2007) also varies by ethnicity. Of those women having abortions in 2007, 31% of white, 48% of black/black British and 28% of Asian women, had previously had an abortion.[2]

In terms of teenage births, Berthoud's 2001 data relate to the 1980s and early 1990s and show that Bangladeshi and Pakistani women had higher rates of teenage motherhood (with a majority of births within marriage) compared to white women. Although often culturally acceptable for these ethnic groups when within marriage, teenage motherhood can nevertheless have socioeconomic and educational implications. More recently, however, there has been a marked decline in early parenthood in South Asian groups in Britain, with all groups having lower than average incidence of teenage motherhood.[3,4]

Expanding upon the data presented by Dr Gupta on the National Chlamydia Screening Programme (NCSP), there are clear differences between ethnic groups in terms of positivity. Groups with the highest positivity include those of mixed, black Caribbean and other black ethnicity and those with the lowest positivity include those of Chinese and Asian/Asian British origin.[5] Although the observed differences in positivity are consistent with ethnic variations in sexual behaviour noted in the National Survey of Sexual Attitudes and Lifestyles (Natsal 2000),[6] we should also consider that the differences observed to date may be influenced by other factors. For example, screening is not yet national and may be missing areas and local ethnic groups with higher/lower positivity. Differences in health care-seeking behaviour/service access between ethnic groups will also mean some groups are screened more than others.[5]

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Missing IUS arms?

We want to describe a couple of cases that serve to demonstrate that the hormone capsule of the Mirena® intrauterine system (IUS) can dislodge during removal thus changing its appearance, As a result, careful examination of the device is required to prevent further unnecessary investigations.

A 58-year-old woman presented to her general practitioner for removal of a Mirena IUS as it was no longer required. It had been inserted at the practice 7 years previously to provide the progestogen component of her hormone replacement therapy.

At the time of removal the cervix and the IUS threads were visualised. More traction than usual was required on the threads to remove the device. On inspection it appeared that the horizontal arms had become detached as they were not evident and the vertical main stem of the IUS had been removed with the hormone release capsule attached.

The patient was asymptomatic and was allowed home. A transvaginal ultrasound scan was performed on an outpatient basis. The scan demonstrated echogenic specks at either end of the endometrium in longitudinal section, and in cross-section specks were noted within the lateral walls of the uterus. It was queried whether these represented the arms of the IUS. The patient was then referred to the gynaecology department, for consideration for operative hysteroscopy to remove the retained arms.

A 50-year-old woman presented to the colposcopy clinic with moderate dyskaryotic smears. She had undergone two previous large loop excision of the transformation zone (LLETZ) procedures for cervical intraepithelial neoplasia (CIN) with complete excision at each. On this occasion colposcopy examination was limited because of unsatisfactory views of the squamo-columnar junction. It was decided the patient would have a further LLETZ treatment with removal and reinsertion of the Mirena IUS under general anaesthesia.

At the time of the procedure it was noted that the IUS threads were visible and the internal cervical os was tight. Again more traction than usual was required on the threads to remove the device. On inspection it was thought that the arms had become detached; the long stem of the device with the hormone release capsule present was attached to the threads. A saline hysteroscopy was therefore performed to locate the IUS arms. Good views of the entire cavity failed to demonstrate the presence of IUS pieces or perforation. The LLETZ procedure was performed and a new IUS inserted. The patient underwent an uneventful post-operative recovery.

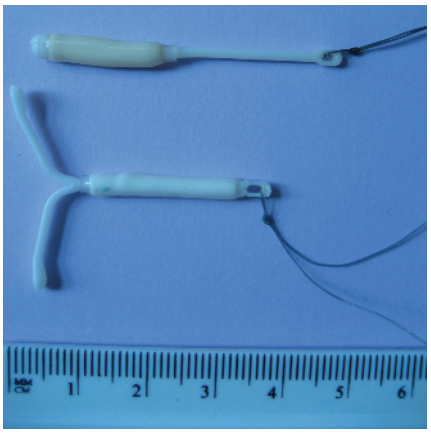

Figure 1 The intrauterine system (IUS) shown in the upper part of the photograph has been removed entirely but its appearance is atypical. The IUS in the lower part of the photograph has a normal appearance

In both cases, when the removed IUS was re-examined, it became apparent that the entire device had been removed from the uterine cavity. The arms were still attached to the main stem of the IUS. The hormone release capsule, usually situated at the base of the vertical stem, had migrated up the shaft, trapping the arms and bringing them together in the midline, making it appear as if they had been detached (Figure 1).

The majority of IUS are removed without difficulty. There are no published cases of IUS arms becoming detached. However, an intrauterine-retained hormone release capsule following IUS removal has been documented.[1]

The common theme in the two patients described above and Forrest *et al.*'s patient[1] is difficult retrieval of the device requiring more traction on the threads than normal. This presumably led to the hormone capsule being dislodged, either migrating up the device and getting stuck covering the arms or becoming detached altogether. Clinicians should always check IUS devices after removal. They should also be aware that after a difficult removal the capsule can migrate and obscure the arms but the device remains complete. Knowledge of this possibility will prevent patients being subjected to unnecessary investigations and interventions to find 'missing' IUS arms and for appropriate investigations and interventions when the capsule has detached completely.

The whole of the IUS device is radio-opaque and can be located with either X-ray or ultrasound.[2] Transvaginal ultrasound is the first-line investigation because it provides the best images to help determine whether or not the IUS is correctly sited within the uterus. The vertical stem of the IUS is visualised in the sagittal plane with multiple reflective parallel planes and in the axial plane as a single echogenic focus.[3] However, in the cases reported here the vertical stem was missing. Horizontal arms are rarely seen in the uterus unless it is possible to obtain a coronal view.[3] In view of this difficulty abdominal X-ray would confirm whether or not the horizontal arms of the IUS were within the pelvis. This would be useful, especially prior to embarking on hysteroscopic investigation.

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Reply

We would like to take the opportunity to respond to Dr Torbe *et al.*'s letter.[1]

Extremely rare, isolated case reports of hormone cylinder dislocations in the Mirena® intrauterine system (IUS) similar to the ones described by the authors have been received by the company's Pharmacovigilance and Quality Assurance Unit. The company's investigations have shown that these cases could not be attributed to a quality defect of the product. Difficult removal has been found as the underlying cause, and no further adverse effect in the Mirena user are mentioned in the majority of cases.

To make physicians aware of this extremely rare situation, and to avoid unnecessary interventions in search of 'missing' Mirena arms, the company has recently introduced the following statement into the Core Safety Information for Mirena: "After removal of Mirena®, the system should be checked to be intact. During difficult removals, single cases have been reported of the hormone cylinder sliding over the horizontal arms and hiding them together inside the cylinder. This situation does not require further intervention once completeness of the IUS has been ascertained. The knobs of the horizontal arms usually prevent complete detachment of the cylinder from the T-body".

Implementation of this statement into the local product information is currently ongoing in all countries where Mirena is marketed, and it was submitted at the beginning of December 2008 to the Medicines and Healthcare products Regulatory Agency (MHRA) to be implemented in the UK.

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Reference
1 Torbé EJV, Eddowes E, Aston K. Missing IUS arms? [Letter]. *J Fam Plann Reprod Health Care* 2009; **35**: 131.

Serious morbidity with long-term IUD retention

We have recently encountered four patients with serious intraperitoneal sepsis over an 18-month interval (2007/2008). Each was associated with long-term retention of a copper intrauterine device (IUD), which was identified as the likely source of infection. The IUDs had been *in situ* for 8, 15, 18 and 20 years, respectively. Three women were several years into their menopause. All four women presented as systemically unwell with a complex pelvic mass. One had ureteric obstruction at the site of the abscess, simulating gynaecological malignancy. In all cases laparotomy was technically difficult owing to the inflammatory pelvic mass adhering to bowel. Intermediate or prolonged hospitalisation resulted and, without intensive care, two of the women would probably have died.

Pelvic actinomycosis was reported in the two patients' histology. Cultures of frank pus grew *Actinomyces* sp. in a third. Actinomyces-like organisms (ALOs) had been reported on the last smear of the fourth woman. In 2004 she had undergone appendicectomy, which showed