suggest that this was not in the patients' best interests given that it contradicts the advice of the RCOG and the Charing Cross Hospital GTN website.

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1 *UK Medical Eligibility Criteria for Contraceptive Use (UKMEC 2009).* 2009. http://www.fsrh.org/admin/uploads/UKMEC2009.pdf [Accessed 10 February 2010].
2 *UK Medical Eligibility Criteria for Contraceptive Use (UKMEC 2005/2006).* 2006. http://www.fsrh.org/admin/uploads/archive/UKMEC2005_06.pdf [Accessed 10 February 2010].
3 Gaffield ME, Kapp N, Curtis KM. COC and IUD use amongst women with gestational trophoblastic disease. *Contraception* 2009; **80**: 363–371.

Reply

In response to Dr Robinson's letter[1] we can say that the use of combined hormonal contraception (CHC) in women with gestational trophoblastic disease (GTD) was extensively reviewed by a multidisciplinary working group of worldwide experts for the WHO Medical Eligibility Criteria (WHOMEC) update in 2009. As a result of this systematic review of published evidence, and taking into account the opinion of experts, a decision was made to advise a Category 1 (unrestricted use) for the use of CHC in women with GTD with decreasing or undetectable levels or indeed with persistently elevated levels or malignant disease.

It is recognised that management of GTD varies worldwide. Nevertheless, based on evidence around risks, there is no good published evidence that use of CHC in women with GTD worsens outcomes.

The UK Medical Eligibility Criteria (UKMEC) Consensus Group, which included a variety of health professionals (including representation from the Royal College of Obstetricians and Gynaecologists, the Faculty of Sexual and Reproductive Healthcare, and general practice), agreed to uphold the new WHOMEC Category 1 for CHC use by women with GTD and persistently elevated serum human chorionic gonadotropin (hCG) levels or malignant disease. The UKMEC Consensus Group could find no evidence to support a Category 3 for the use of intrauterine contraception in women with decreasing or undetectable serum levels of hCG. As there is no evidence that use of intrauterine contraception by women with GTD and decreasing or undetectable serum levels of hCG poses any risk, a Category 1 was given as in the UKMEC 2005. The Gaffield review paper[2] was published after the review of evidence in preparation of the UKMEC update and therefore was not quoted.

It is clear that any guideline such as UKMEC needs to be taken as a guide and should not replace clinical judgment. Expert opinion and discussion with specialists should be sought in complex and rare situations such as women with GTD. Best attempts can be made to ensure coherence of guidance across colleges in the UK but this requires reciprocal arrangements from all colleges to ensure advice reflects evidence and opinion.

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1 Robinson G. Combined pill and GTD [Letter]. *J Fam Plann Reprod Health Care* 2010; **36**: 106–107.
2 Gaffield ME, Kapp N, Curtis KM. COC and IUD use amongst women with gestational trophoblastic disease. *Contraception* 2009; **80**: 363–371.

Resolution of localised lipoatrophy at the site of Implanon© insertion

I have previously reported a 40-year-old woman who had had an Implanon© implanted into her right upper arm.[1] At the site of the Implanon in the middle of the inner aspect of her right upper arm it was noticed at the time of implant removal 3 years later that she had a localised area of lipoatrophy extending approximately 2 cm either side of the implant and along a length of approximately 15 cm extending above and below the ends of the implant. In this 4 × 15 cm area there was virtually no subcutaneous fat. The lipoatrophy had been asymptomatic and had had no effect on the patient who had to have the area of lipoatrophy demonstrated to her.

Six months after removal the area of lipoatrophy had completely resolved and the patient remains asymptomatic. Both arms looked the same with return of the subcutaneous fat on the affected side. It has been suggested[2] the lipoatrophy might have been due to the use of topical steroids but a review of the patient records shows they have not been prescribed over the last 8 years and the resolution of the lipoatrophy after removal of the implant does suggest Implanon as a cause.

I suggest that localised lipoatrophy is added to the rare side effects described for Implanon and that the possibility of it developing, even if it is reversible, further motivates correct placement of the implant.

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References
1 Lindsay P. Localised lipoatrophy at the site of Implanon© insertion [Letter]. *J Fam Plann Reprod Health Care* 2009; **35**: 266.
2 Mohlala B, Falowo F. Reply to "Localised lipoatrophy at the site of Implanon© insertion" [Letter]. *J Fam Plann Reprod Health Care* 2009; **35**: 266.

Reply

Dr Lindsay should be commended for reporting[1] and following up on this case;[2] indeed all adverse events should be followed up and the information collated used to assess causality or the relationship between the drug and the event.

In the case reported by Dr Lindsay, causality cannot be fully established and, as such, the event of localised lipoatrophy cannot be classified as caused by Implanon©. The fact that, at the 6-month follow-up assessment after implant removal the event had resolved is not enough to establish causality.

When we applied the Naranjo Scale to this case the maximum score we achieved was two out of a possible ten.[3] The Naranjo Scale is a questionnaire designed by Naranjo *et al.* for determining the likelihood of whether an adverse drug event is actually due to the drug rather than the result of other factors such as pre-existing condition.[3]

The score of two suggests the relationship is possible; however, it is too low to classify this event as definite or probable. Therefore Dr Lindsay's conclusion regarding this event in our opinion is not valid. Furthermore, the patient's pre-existing autoimmune condition is still a confounding or alternative explanation as previously mentioned in our letter.[4] Excluding the use of steroids is very important in assessing this case, this provided valuable information; however, the evaluation of all the information gathered so far is not adequate to allow Implanon to be classified as a definite or probable cause of this event.

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3 Naranjo CA, Busto U, Sellers EM, Sandor P, Ruiz I, Roberts EA, *et al.* A method for estimating the probability of adverse drug reactions. *Clin Pharmacol Ther* 1981; **30**: 239–245.
4 Mohlala B, Falowo F. Reply to "Localised lipoatrophy at the site of Implanon© insertion" [Letter]. *J Fam Plann Reprod Health Care 2009;* **35:** 266.

Use of an expired Cu-IUD

I was ready to fit an intrauterine device (IUD) in the CASH clinic when the nurse announced that the expiry date of the Flexi T-300© was 6 months previous. Having already opened the pack, I continued to fit the IUD to save National Health Service money, confident in the knowledge that many years ago at an update conference I had heard an expert panel state that it is safe to use an IUD up to a year after the expiry date. Common sense dictates that an expired Cu-IUD is not the same as expired sandwiches, for example.

Shortly after this episode occurred I was on annual leave. During my holiday, one of my colleagues contacted the patient and subsequently replaced the IUD, informing the patient that there was a risk of pregnancy. I was surprised at this since I am aware that there are a number of problems associated with IUD fitting and removal *per se*. One could argue that the IUD could have been left *in situ* for 4.5 years instead of the normal 5 years.

I would be interested to know whether any other Journal readers have used an expired IUD and, if so, what the outcome was. Was my colleague right to replace the IUD on this occasion?

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Reply

I would like to respond to Dr Yadava's letter[1] on behalf of Williams Medical Supplies, a manufacturer of copper intrauterine devices (IUDs). Most Cu-IUDs have an expiry date of around 4 years. This is because the product's sterility can be guaranteed over this time frame. Once the expiry date has passed, the product is no longer guaranteed to be sterile and therefore we would not recommend fitting an expired IUD in a patient because of potential infection concerns. If an expired product is fitted by mistake, then there are two courses of possible action. One would be to undertake close patient observation over an agreed time span to ensure infection has not occurred. The second option would be to remove the IUD and fit a new one that is within its expiry date.

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Reference
1 Yadava RP. Use of an expired Cu-IUD [Letter]. *J Fam Plann Reprod Health Care* 2010; **36**: 107.

Reply

I would like to respond to Dr Yadava's letter[1] on behalf of the Clinical Effectiveness Unit of the Faculty of Sexual and Reproductive Healthcare. We are not aware of any evidence or