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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References
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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References
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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References
1 Lindsay P. Localised lip atrophy at the site of Implanon© insertion [Letter] J *Fam Plann Reprod Health Care* 2009; **35**: 266.
2 Lindsay P. Resolution of localised lipoatrophy at the Implanon© insertion site [Letter]. *J Fam Plann Reprod Health Care* 2010; **36**: 107.
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

recommendation that intrauterine devices (IUDs) are safe to use after the manufacturer's expiry date. Guidance from the Medicines and Healthcare products Regulatory Agency (MHRA) on the safe use of medical devices advises checking before use whether a device is within its expiry or use-by date.[2]

Training material from Family Health International states that the expiration date printed on IUD packaging indicates the date when the sterile packaging expires, not the date when the IUD's effectiveness expires.[3] Even in the resource-constrained settings for which this information is intended, it is advised that an IUD is used only if the sterile package has not expired.

Therefore, Dr Yadava's patient was probably not at increased risk of pregnancy but she may have been at increased risk of infection. In the event of inadvertent insertion of an expired IUD, the patient should be informed of the error and advised of the risks of retaining or replacing the IUD. If the IUD has only recently expired or if the IUD has been inserted without any infective complications, then the risks of replacing the IUD may outweigh the benefits.

Confusion has possibly arisen because in contraceptive literature the term 'expiry date' is often used to describe the limit of an IUD's recommended duration of use. This 'expiry date' can be exceeded in women who are over the age of 40 years at the time of insertion.[4]

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References
1 Yadava RP. Use of an expired Cu-IUD [Letter]. *J Fam Plann Reprod Health Care* 2010; **36**: 107.
2 Medicines and Healthcare Regulatory Agency. *Medicines and Human Devices in Practice – A Guide for Health and Social Care Professionals.* 2008. http://www.mhra.gov.uk/Safetyinformation/Generalsafetyinformationandadvice/index.htm [Accessed 13 February 2010].
3 Family Health International. Contraceptive Technology and Reproductive Health Series. *Intrauterine Devices (IUDs).* 2004. http://www.fhi.org/training/en/modules/iud/s3pg3.htm [Accessed 13 February 2010].
4 Faculty of Family Planning and Reproductive Health Care Clinical Effectiveness Unit. *Intrauterine Contraception.* 2007. http://www.fsrh.org/admin/uploads/CEUGuidanceIntrauterineContraceptionNov07.pdf [Accessed 13 February 2010].

Correspondence about the recent article on "Nurse Training in Sexual and Reproductive Health"

The Journal has received a number of letters written in response to the Personal View article entitled "Nurse training in sexual and reproductive health" by Shelley Mehigan, Wendy Moore and Linda Hayes that appeared in the January 2010 issue of the Journal. The very fact that this article has attracted the greatest number of letters of any article published in the Journal in recent years is evidence of the article's timeliness and relevance to many of the Journal's readers. The individual letters received by the time this Journal issue went to press, and the response from Shelley Mehigan and Wendy Moore, are reproduced here in full.

Letters

I would like to thank the authors of the article[1] on nurse training in sexual and reproductive health in the January 2010 issue of this Journal for very clearly setting out the current situation regarding nurse training in this specialty and the history to the situation.

I agree with the authors that post-registration training in contraception and sexual health has been an area of concern for some years now. Certainly when I joined the Faculty Associate Members Working Group 3 years ago this was one of the main issues on our agenda. We set out to look at whether nurses could do the Faculty Diploma (the DFFP as it was known as then) along with doctors. This was not possible as it is a medical diploma and qualification. This has come full circle and will be revisited. A lot of work has taken place within this group, including attempting to map current training provided across the country.

- **Recruitment.** As a Senior Nurse Manager in a service employing over 60 SRH nurses I find the lack of standardisation of training difficult when recruiting; to ascertain from applications whether the candidate has completed a recognised training or a skills course can be difficult, in addition 'recognised' courses can vary significantly. From the nurse's point of view there seem to be enthusiastic candidates who have not attended recognised contraception and sexual health courses but who are keen to move into the specialty and it seems some nurses are having difficulty in knowing exactly which training is required by employers and/or accessing the training.
- **Access to training.** From the nurse's position, to undertake a contraception and sexual health course at a Higher Education Institute (HEI) can take 3–9 months to complete. Managers are reluctant to give study leave to enable nurses to access the training, and nurses are struggling to balance the demands of their job with lengthy assignments. In some instances, after 6 months two modules have been completed and the nurse is trained in contraception; however, yet another module is required to complete cervical cytology screening and yet another for management of sexually transmitted infections (STIs).
- **Multidisciplinary training.** I believe that training in contraception and sexual health should be multidisciplinary. Nurses and doctors should be able to access the same training and undergo the same assessment; it would follow on that standard accreditation is required. The Faculty has welcomed Associate Members with the AMNG working group and with Associate Members represented on other committees. If the Faculty could extend accreditation to clinicians other than doctors this could address many of the issues, although this is currently not possible.
- **Standardised training.** The content of the training must be standardised and it is vital that training from all providers and HEIs is *up to date*, *evidence-based* and reviewed by practising experts in SRH. The course should cover contraception and sexual health to meet the needs of integrated services. Cytology training and updating is another area that would benefit from standardising across disciplines.
- The new e-learning for the DFSRH will be *accessible* for all to learn in their own time and at their own pace. Assessment would be standard. The Course of 5 may be richer for having doctors and nurses training together. I believe the *clinical placement and clinical assessment* is a very important part of the SRH nurse training and I would not like to see it reduced. This part of the assessment is not undertaken by HEIs but by local SRH departments. Therefore this could continue whether or not the nurse is doing a university-accredited course. Locally we provide clinical placements of 12–14 weeks with usually one session a week. If this can be provided with longer sessions over a shorter time period then the clinical training could be completed in several weeks.
- Many post-registered nurses are not doing the contraception and sexual health training as part of a pathway to get a degree, but to achieve the competencies required to work in the area. For those nurses who choose to do it as part of a degree or masters, a standardised course should be available at HEIs but I would recommend that the course includes the same basic content as the standard training accessed by doctors and nurses (i.e. the e-learning, Course of 5 and clinical placement).
- **Accreditation** needs to be addressed urgently in view of the Royal College of Nursing (RCN) changes. We plan in future to provide accreditation as a Department of SRH to nurses trained in subdermal implants (SDIs). However, this has implications for those who wish to become primary trainers for their medical colleagues.

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Reference
1 Mehigan S, Moore W, Hayes L. Nurse training in sexual and reproductive health. *J Fam Plann Reprod Health Care* 2010; **36**: 5–6.

I am corresponding in response to the article[1] in the Journal on nurse training in SRH, and want to say that I totally agree with all of the points the authors raised in this article.

I am the lead nurse for sexual health in Northamptonshire Healthcare Foundation NHS Trust with 27 family planning (FP) nurses and 23 genitourinary medicine (GUM)/HIV nurses. Training, education and development of their roles is one of my key responsibilities.

In the days of the English National Board (ENB), as the authors quite rightly say, we knew the standards required. Currently we support FP students on courses at De Montfort University Leicester and are very satisfied with this course in terms of standards and support from tutors, and so on. However, there have been students from other areas where we have been less than impressed with the course offered.

I think the proposal to link in with the DFSRH standards is an excellent progression, particularly as nurses take on such an integral advanced role in this specialty. With advanced practice, I as a manager like to know that when a new member of staff has attended specific courses, it is at the level required to carry out the job competently and safely.

I welcome involvement in these new initiatives.

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Reference
1 Mehigan S, Moore W, Hayes L. Nurse training in sexual and reproductive health. *J Fam Plann Reprod Health Care* 2010; **36**: 5–6.

I was most interested to read the nurse training article[1] in the Journal.

I have a particular interest in nurse training as one of my roles at The Margaret Pyke Centre is Nurse Trainer for inserting and removing subdermal implants. I am also training to be a Faculty Nurse Trainer for Doctors in this specialty.

It seems to me that the Royal College of Nursing (RCN) are implementing policies that positively discourage Nurse Trainees, by the large increase in accreditation and re-accreditation fees. Primary care trust budgets seem to be so tight that they are not providing the money for the fees, so that the only way for a nurse to obtain accreditation is to pay for it herself. The nurses that I have trained have had difficulty in affording the fee of £35 (£75 for non-RCN members), so you can imagine the extra difficulty that a fee of £300 (£400 for non-members) is going to cause. It is definitely going to reduce the number of nurses coming forward for the programme. Furthermore, this disincentive to increasing the pool of competent people is contrary to the stated policy of promoting long-acting reversible contraception (LARC).