

Progesterone receptor modulators

The review¹ on 'Progesterone receptor modulators in gynaecological practice' in the April 2010 issue of the Journal is a valuable contribution to the available literature on a currently important subject.

In the section on 'Contraception' the authors have dealt at length with mifepristone. Since the latter is not licensed for postcoital contraception, it would have been appreciated if the authors had dealt with some salient features of the recently introduced second-generation selective progesterone receptor modulator, ulipristal acetate, which is licensed for postcoital contraception for up to 120 hours after unprotected sexual intercourse.

The primary mechanism of action is inhibition of ovulation, but alterations in the endometrium also have anti-implantation effects.² Ulipristal acetate appears to be a more potent inhibitor of ovulation than levonorgestrel and hence may be relatively more effective as a method of postcoital contraception.³⁻⁵

While the post-implantation use of levonorgestrel has not been associated with any harm to an early pregnancy, as yet the same has not been established for ulipristal acetate.⁶

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Reply

We thank Dr Bhathena¹ for his interest in our recent review article.² The purpose of the review was to highlight the many different indications in gynaecological practice, in which progesterone receptor modulators (PRMs) may be applied and to focus on the potential health benefits of PRMs. PRMs have an endometrial antiproliferative effect in the presence of follicular phase estrogen levels, and this constitutes the basis of many of their potential advantages in the management of gynaecological conditions.

Currently, the only licensed indications for PRMs [mifepristone for termination of pregnancy and ulipristal (UPA) for emergency contraception (EC)] both relate to fertility control. Ulipristal has only recently received a licence based on good evidence regarding its effectiveness for EC even when taken up to 120 hours after intercourse.^{3,4}

This Journal has previously published very informative commentaries and correspondence on the topic of UPA in emergency contraception.⁵⁻⁷ Like other PRMs, UPA is associated with suppression of ovulation and menstruation via an effect, which may not be explained merely by progesterone antagonism.^{8,9} Registration of UPA followed the publication of the UPA trial and meta-analysis in the *Lancet* paper.³ The authors of this paper pointed out that regarding the mechanism of action, an effect of

UPA on the endometrium could not be ruled out although the effect on ovulation inhibition is potent. With respect to any potential harmful effect on pregnancy, it is reassuring to note that the rate of miscarriage between women treated with levonorgestrel and UPA for EC was not different.

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Nurse training in SRH

I have just read the Personal View¹ on 'Nurse training in SRH' in the January 2010 issue of the Journal and I agree with most of what Shelley Mehigan and her colleagues have written.

It would seem sensible that sexual and reproductive healthcare (SRH) training is unified for doctors and nurses. Full membership of the Faculty of Sexual and Reproductive Healthcare (FSRH) should be open to both. Nurse practitioners should be allowed to undertake the same training and sit for the Letters of Competence (LoCs), Diploma of the FSRH (DFSRH) and Membership of the FRSH (MFSRH). SRH, in particular, is ideally suited for such progress. Increasingly, nurse practitioners are providing Level 1 and Level 2 services and doing the bulk of the routine clinical work.

The Mehigan *et al.* article did not mention that several Colleges already allow other health care practitioners to undertake their training and examinations. I am sure that readers are well aware of this; here are some good examples.

1 Faculty of Public Health of the Royal Colleges of Physicians

Other health care professionals, in addition to doctors, may undertake the full training in public health and then be placed on the Voluntary Register of Public Health Specialists. They can take the MFPH (Membership of Public Health) examination. They may be appointed as Consultants in Public Health and interestingly can act as Leads in SRH.

2 Royal College of Pathologists

Training and Membership of the Royal College of Pathologists (MRCPATH) is open to scientists, such as virologists and biochemists, and they are

not necessarily required to have a medical qualification.

3 Royal College of Surgeons of Edinburgh

The DIMC (Diploma in Immediate Medical Care) of the Royal College of Surgeons of Edinburgh is open to doctors, nurses and paramedics working in this field.

4 Society of Apothecaries

The DFCSA (Diploma in the Forensic and Clinical Aspects of Sexual Assault) is open to nurses and midwives as well as doctors. This particular diploma is very relevant to SRH practice. The DMCC (Diploma in the Medical Care of Catastrophes) is also open to nurses as well as doctors.

5 University diplomas

Many of the University diplomas are open to a wide range of health care professionals [e.g. the Diploma in Palliative Care of Cardiff University (nurses, doctors) and the Diploma in Medical Law of Northumbria University (nurses, managers, lawyers, doctors)].

6 Medical Royal Colleges and Nurse Training

There should be no great impediment to the Medical Royal Colleges working more closely together with the RCN and universities on unified nurse and doctor training in shared fields.

The Royal Charter of the Royal College of Obstetrician and Gynaecologists (RCOG) (1947) states the purpose is: "The encouragement of the study and the advancement of the science and practice of obstetrics and gynaecology". This is a broad definition and should allow the RCOG and the FSRH to take a progressive view of joint training.

In conclusion, I fully support the Personal View article and would be happy to discuss it further with the authors. I will also be interested to hear about future progress on this issue.

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Need for IUD fitters to have expertise in resuscitation

I was pleased to read the Personal View¹ article on 'Nurse training in SRH' in the January 2010 issue of the Journal.

We have a related issue at the moment and would welcome comment from other Journal readers. It concerns the Faculty's guidance on resuscitation for nurses when fitting IUDs.² It suggests someone competent to give intravenous (IV) drugs must be available. The Royal College of Nursing (RCN) has also made a statement³ supporting this but when contacted the RCN said it supported it because it was Faculty guidance and didn't seem to understand the consequences or practicalities. It would appear that there is no named person to discuss this matter with there.

We currently have nurse-led community clinics that provide intrauterine devices/intrauterine systems (IUDs/IUSs) with no doctor present. Indeed we have very few doctors in such clinics.

None of us have ever cannulated or given IV drugs (including me for over 20 years). Some people have taken blood from time to time but none of us have any need to do so regularly. We are advised that to be competent to do so would involve weekly IV drug administration/cannulation, which would remove us all from clinic to theatre or similar to do so. Our resuscitation department is amazed by the guidance.

We surely cannot be the only family planning unit that has predominantly nurse-led clinics, and I cannot believe all IUD fitters have extensive