

the anterior lip before applying the Allis forceps and then to proceed to the depth of the internal os for the second and third injections. Whether this is achieved through the cervical tissue at 3 and 9 o'clock according to Dr Gray, or via the external os and then injecting obliquely around the internal os, is academic. Both approaches are likely to have the same effect. It could be argued that Dr Gray's approach is simpler for trainees to learn.

Dr Gray has been offering injectable local anaesthesia for 16 years and I for 39 years. We both find that it is painless to deliver.

At the Margaret Pyke Centre we have in the past used Citanest® (prilocaine) but now use Scandonest® (mepivacaine) and though Dr Gray suggests it may be less well tolerated I have not found this to be so. Is there a comparative study?

I am happy Dr Gray rejects lignocaine gel as little more than placebo. I would go further and say it is simply a salve to our guilty consciences, to make us feel that as medical professionals we are doing what we should to minimise pain. It has little or no effect on cervical pain or shock. I am aware that many colleagues use it widely (their sincere belief that it works adds to its placebo effect) but I disagree most strongly. They may praise its efficacy but it cannot compete with injectable anaesthesia.

Dr Gray and I have the same response from women who have had fittings with and without injectable local anaesthesia, universally reporting a much improved experience with anaesthetic.

We agree, too, on the reaction of nurse practitioners trained to use these techniques and that they are happier to offer intrauterine device (IUD) fitting knowing it will be less traumatic. It is, as Dr Gray says, a transformative experience.

Our one point of difference is that Dr Gray invites women to opt in for local anaesthesia and I allow them to opt out of it. To make local anaesthesia the default position out of which any woman can opt is in itself a transformative position. So far none have opted to say no to anaesthesia. This is not difficult to understand.

I have been advised by medical ethicists that causing unnecessary and avoidable pain and distress by withholding anaesthesia for IUD/intrauterine system fittings does not in itself constitute an assault. However, as Dr Gray points out, it could well be deemed unethical.

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REFERENCE

1. **Gray S.** Option of local anaesthetic for IUD fittings [Letter]. *J Fam Plann Reprod Health Care* 2011;**37**:189–190.

Option of local anaesthetic for IUD fittings: author's response

In response to Dr Gray's letter¹ published in this Journal issue, I am heartened to see that we agree in principle. Dr Gray articulately describes her injection technique. There are many different possible injection sites and protocols but two important principles are to anaesthetise