Women should be routinely offered ILA for IUD fittings

It is after the experience of my straw poll of 250 general practitioner (GP) and family planning doctor inserters at an update session showed over 90% of us do not even *offer* injectable local anaesthesia (ILA), and finding this reflected in seminars, updates and training sessions with GPs mostly in the Southern parts of England, that I have based my current position. Of course, as Dr Bacon[1] and even Dr Jones[2] maintain, day-to-day events affect the patient as we can by our approach, our understanding and empathy – we are medical professionals because we passionately care about people – but some pains resistant to the likes of vocal local will still need the magic of anaesthesia.

And this is why, to counter all those in our specialty who take it upon themselves to decide for women that they do not need anaesthesia, that I have taken what appears to be the radical position of making ILA the default position. I now say to all women, parous included: "We use ILA routinely. Is that OK by you?".

My small audit of my last 200 insertions includes two women who have asked not to have it. One was parous, one nulliparous. Of this 200, 50 women were parous thus giving me an exceptional demographic of 75% nulliparity. Nevertheless 49 of the parous women said "Yes please".

It is true that some, but not all, parous women will not feel pain during insertion of an intrauterine device (IUD).

My litany, however, continues that this is no reason not to discuss anaesthesia with all parous women.

I am a man and will never experience the potentially transformative rigours of childbirth. It has been said many times, and most recently in Caitlin Moran's excellent *How To Be A Woman*, that the pains of childbirth put a new perspective on many things, transitory pain being one of them. Thus if a parous woman decides that she can cope with such potential fleeting pain *it is for her to decide*.

As is clear in these dialogues there are many opposing points of view and attitudes but it is not for a medical professional to assume that parous women will universally accept pain in the same way. The great pattern of things dictates that we are all different. Thus I cannot be moved from the position that all women must at least be offered ILA.

I agree wholeheartedly with Dr Bacon's contention that this is a complex and not a simple issue and is laden with ethical resonances at every turn.[1] She talks movingly of the stressful situations we can sometimes impose on patients and that there are approaches whereby we can minimise stress and consequent pain. I agree that IUDs are not as available as they should be.

I am pleased to see that Dr Bacon maintains that our approach demands different practice in different circumstances "depending not only on parity but on the woman's total experience".[2]

But parity is a guide and no more. I have commonly had experience of fitting an intrauterine system in a nullip with no LA and no pain and then reaching for the local after a para 2 woman has cried out after simple application of the light Allis forceps onto the anterior cervical lip.

Dr Jones underlines his "appreciable experience", his 25 years being a not inconsiderable percentage of my 40. He points out that he did not only deal with contraception but the totality of sexual health care. This is hopefully what we all do as a matter of course.

It is admirable that Dr Jones promoted the use of intrauterine methods. I am sympathetic to his problems with his Trust closing the very clinic where 75% of his patients were using IUDs. Yet it concerns me greatly that at no time did he find the use of ILA "either necessary or desirable". And I take exception to his suggestion that the use of ILA unnecessarily "medicalises" the procedure. Do dentists "dentalise" their practice with their injections? It is of course down to how we do it, our technical skill and the empathy we create with the patient. Otherwise a speculum and an examining couch are themselves medicalising.

Dr Jones suggests that with proper knowledge of the anatomy and relations of the uterus insertions are easy and pain-free as they have been for him during the past 20 years. This is an amusing variant of the "I am so good I don't cause pain" argument I have so often encountered. And without this proper anatomical knowledge no one should even attempt to insert an IUD.

Do I cause pain because I don't fully understand the anatomy of the cervix, its canal and the uterus? Am I a Stranger in a Strange Land?

In the end it is better to use unnecessary local anaesthetic than to cause unnecessary pain. But then I do not appear to work in the pain-free world so many lucky doctors inhabit.

Sam Hutt, MB BChir, FFSRH

Associate Specialist, Margaret Pyke Centre, London, UK; samhutt9@gmail.com

Competing interests None.

J Fam Plann Reprod Health Care 2011;**37**:253–254. doi:10.1136/jfprhc-2011-100203

REFERENCES

1 **Bacon L.** Option of local anaesthetic for IUD fittings [Letter]. *J Fam Plann Reprod Health Care* 2011;**37:**253.
2 **Jones K.** Use of injectable local anaesthesia for IUD/IUS fitting [Letter]. *J Fam Plann Reprod Health Care* 2011;**37:**253.