LETTERS

GP use of anti-D

Madam,

Rhesus haemolytic disease of the newborn is now a rare condition. Deaths from it in England have fallen from 18.4 per 100 000 live births in 1977 to 1.3 per 100 000 in 1992.[1] This improvement is partially due to the use of anti-D immunoglobulin in Rhesus negative women who have bled in early pregnancy. Vaginal bleeding is common, occurring in about 21% of all pregnancies and 11-16% of pregnancies miscarry.[2] Early pregnancy bleeding is increasingly managed in primary care, one recent study showing only 45% of women being admitted to hospital.[2] Therefore, the responsibility for prevention of Rhesus isoimmunisation has transferred in a large part to general practice.

We studied the use of anti-D in the management of early pregnancy bleeding in a training general practice in Exeter, Devon. The practice population is 6430.

A computer search revealed 73 women who had early pregnancy bleeding between 1994 and 1998. Twenty-eight were excluded because their miscarriage had occurred before they had registered with the practice or because they had self-referred to the Accident and Emergency department. The remaining 45 women had had 61 episodes of early pregnancy bleeding presenting in general practice, and 25 of these episodes were managed solely in primary care. Of the 61 episodes, 12 were in women who were Rhesus negative, and four of these were managed solely in primary care. None of these four received anti-D.

Five of the eight admitted to hospital had anti-D administration documented on their discharge summary. The other three may have received anti-D, but this is unknown. Therefore, between four and seven women (7-11%) received inadequate care.

The results of this study will not be applicable to all general practices. However, questionnaire surveys suggest that over 70% of GPs do not administer anti-D routinely,[3,4] and their results are likely to be similar. If GPs are to continue managing early pregnancy bleeding in the community, then they need a protocol which incorporates the determination and recording of the woman's blood group early in pregnancy. Furthermore, supplies of anti-D will need to be easily available within the practice. Without such care, we may see a rise in haemolytic disease of the newborn, which should have been preventable.

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Levonorgestrel IUS use in Islamic Malaysia

Madam,

I would like to make some observations relating to the use of the levonorgestrel intra-uterine system in Islamic Malaysia.

Muslims have a religious duty to pray five times a day and to fast during Ramadhan. They are forbidden to pray or fast during menstruation as blood is considered a pollutant in the context of Islamic practice. The levonorgestrel system may prevent Muslims from carrying out their religious obligations, due to the initial side effects of irregular breakthrough bleeding that may persist during the first 6 months of use.

The benefit of a 20% amenorrhoea rate in the first year of use of the intra-uterine system has proved to be a disadvantage in some patients in Malaysia. Culturally, there is a widespread belief that the act of menstruation relieves the body of its toxins. When amenorrhoea occurs, some patients interpret this as a build up of toxins in their body, despite reassurance to the contrary. The consequences of presumed building up of toxin may lead to general malaise and lethargy in the patient, and may require the removal of the intra-uterine system.

It is important to counsel Muslim patients fully regarding the possible menstrual side effects of contraceptives, as this may interfere with their religious practices and cultural beliefs. In addition, it may be necessary to select an appropriate time for insertion of the levonorgestrel intra-uterine system, for example 3-6 months prior to Ramadhan, to try to avoid the side effect of vaginal spotting during that month. Adequate counselling is pertinent prior to the use of the levonorgestrel intra-uterine system to improve the acceptance and compliance rate. An alternative method should always be made available to those who decline the levonorgestrel intra-uterine system.

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Psychological effects of sterilisation in India

Madam,

Female sterilisation is the most widely accepted method of contraception all over the world. In developing countries like India, the majority of women accepting this method of contraception are young, uneducated, poor and from a rural background. The decision to undergo sterilisation is usually not their own, but is imposed on them by their mother-in-law, husband or some elder in the family. We have observed that a large number of these women subsequently report to the gynaecology out-patient department with vague symptoms like pain in the abdomen, backache, increase in weight or weakness.

We carried out a study with the aim of comparing the psychological aftermath of female sterilisation amongst rural and urban Indian women. We studied 50 sterilised rural women and 50 sterilised urban women served as controls.

We assessed each of these women, using a rating scale, at their homes during the Reorientation of Medical Education (ROME) programme. We found that there was a very high incidence of depression (72%) in rural women compared to only 8% in urban women. The difference was statistically highly significant ($p < 0.001$).

We also found that there was a marked incidence of somatic manifestations such as somatic anxiety and gastrointestinal symptoms in both groups.

We feel that there should be detailed personal counselling of women before sterilisation, especially in rural areas. Health workers should help women to make a free, proper and correct choice of contraceptive method to be used. This will go a long way to reducing feelings of regret and other long term psychological aftermaths of sterilisation.

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Forgotten IUDs

Madam,

I read with interest the case report on the forgotten IUD.[1] Even though IUDs are supposed to be removed after a variable period of time, some women do not even remember that they have one. During the past 12 months I have come across two patients who were referred to the clinic to rule out malignancy, but who turned out to have forgotten IUDs.

Case 1 A 48-year old lady was referred by her GP with perimenopausal bleeding. She told us that she vaguely remembered that a Lippes loop was inserted 20 years ago but that she later forgot about it. On speculum examination the threads were found embedded in the cervical mucosa. Attempts to retrieve the loop in clinic were abandoned because of pain. She underwent hysteroscopy, D&C and removal of the IUD. No co-existing intra-uterine pathology was found clinically or histologically. Bleeding stopped following the removal of the IUD.

Case 2 A 70 year old lady was referred to us with postmenopausal bleeding. She had never had a smear. Outpatient examination revealed a highly suspicious looking cervix. She underwent a cervical biopsy and hysteroscopy. During hysteroscopy a Lippes loop was found in the uterine cavity and was removed. Biopsy from cervix and endometrium showed only chronic inflammatory changes.

In both these cases no actinomyces-like organisms were isolated. Although rare, forgotten IUDs can present with ominous symptoms and signs that are worrisome to both the doctor and the patient.

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Depo Provera - irregular bleeding management

Madam,

We are writing in response to the paper on the clinical use, effectiveness and side effects of Depo Provera (DMPA), recently published in *The British Journal of Family Planning*.[1]

We agree that DMPA is an extremely safe and effective method of contraception, and that amenorrhoea is a positive benefit for many women. However, we do not fully agree with the statements regarding the management of irregular bleeding in DMPA users.

Disturbances of menstrual bleeding are almost inevitable in DMPA users, with one third to one half experiencing amenorrhoea at 1 year, and the majority of the rest with long cycles and scanty bleeding. Often an explanation of physiology of amenorrhoea will allay the woman's anxieties. However, irregular and heavy bleeding are generally poorly tolerated, and menstrual disturbance is the single major reason given by women for discontinuing DMPA, and all other forms of progestogen-only contraception.

The authors recommend oestrogenic 'treatment' for prolonged bleeding and quote the 1996 WHO report by Said et al[2] to support this. The paper advises the addition of a 30 mcg containing

combined oral contraceptive pill, or conjugated equine oestrogen, or an oestrogen patch for prolonged bleeding. However Said et al, in a placebo controlled trial of 278 women requesting treatment for bleeding disturbances with DMPA, found that 93% stopped bleeding during treatment with 50 mcg of ethinyl oestradiol (EE) with 2.5 mg of oestrone sulphate and 74% with placebo. This amounted to only one less bleeding day and three less spotting days per 90-day reference period with EE compared to oestrone or placebo. There was no residual benefit from treatment. In fact, those who had taken EE had more unpredictable bleeding in subsequent months. In the long term, the groups did not differ in bleeding patterns, or in discontinuation rates for menstrual disturbance. The message from this is that there is currently no effective long-term treatment for the management of bleeding disturbances with progesterone-only contraception. Since the absence of oestrogen is a major health advantage of these contraceptives for some women, there is currently insufficient evidence to advise its use in DMPA users. Counselling before and during bleeding disturbances should remain the cornerstone of management.

Similarly, the authors recommend earlier administration of the next DMPA injection. We are not aware of any published evidence that this is effective.

The mechanisms of irregular bleeding in progestogen-only contraception are unclear, although recent evidence points towards endometrial vascular fragility at the end point of local changes in vascular integrity.[3] Until these mechanisms are understood, it is unlikely that effective treatment for this troublesome bleeding will be available.

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Comments on Implanon review

Madam,

The recent review of Implanon by Edwards and Moore[1] is well timed as it coincides with the withdrawal of the alternative implant, Norplant. One of the main problems with implant technology appears to have been resolved; insertion and removal of the new implant appear to be much easier. In their review of randomised studies only 0.2% of Implanon users had complications as against 4% with Norplant.[1]

One important measure of the performance of any progestogen-only method is the numbers who discontinue because of bleeding problems. Edwards and Moore show in their recent review that 9.4% of 1716 women discontinued because of bleeding irregularities,[1] although the preferred way to report discontinuation rates is as cumulative rates, using the life-table methods.[2] But using the correct statistical method does not overcome the problem of widely different results from different centres and regions, which we discover from another review using the same data.[3] The cumulative discontinuation rate for bleeding irregularities varied 14 fold depending on the region; the rate was 1.5% in South East Asia and Chile, and 21.2% in Europe and Canada.[3] The pooled data, as found in Edwards and Moore's review, are meaningless in the presence of this degree of heterogeneity. The results from Europe and Canada provided by Affandi are more likely to reflect the UK experience of discontinuation because of unacceptable bleeding irregularities.

Edwards and Moore rightly give much attention to trends in bleeding patterns in women who continue using the device. One of the problems with this analysis, however, is that it is heavily influenced by the number of women who discontinue because of bleeding problems, so the rate will appear to fall simply because women who are unable to tolerate the bleeding, and have the implant removed, are also removed from the analysis. As there were major differences in discontinuations for bleeding problems in different regions, pooled data can be misleading.

Some of the studies reviewed by Edwards and Moore were randomised controlled trials comparing Implanon and Norplant. The data on discontinuations with Norplant, however, were not available to the authors. The comparison between the two implants in the European studies is provided in the pooled analysis by Affandi.[3] The discontinuation rate due to bleeding irregularities was 29% in the 129 Implanon users compared to 19% in a similar number of users of Norplant. We are not told if this difference is statistically significant, but it does suggest that the problem of bleeding irregularities may be higher in Implanon users. The introduction of new contraceptive methods benefits from realistic expectations based on good clinical science.

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Letters to the editor are welcome and should not normally be longer than 400 words or have more than five references and type should be double spaced. Except in exceptional circumstances, correspondence should be received within 4 weeks of despatch of the most recent Journal. Correspondents should state their qualifications and address.