# Letters to the Editor

## Clearer guidelines

I propose a Campaign for Clearer Guidelines.

I was pleased to see the title for the most recent Guideline from the Clinical Effectiveness Unit (CEU)[1] for managing vaginal discharge. This will be really useful in general practices and contraception clinics, I thought. But I was so disappointed with how difficult it was to understand. I am afraid most people will look at the title, start to read it and then put it unread into a drawer to 'tackle it when I have time', rather than actively using it in their clinical practice.

Have the writers of the Guideline decided who the target audience is? The information seems poorly focused on the actual clinical setting in which it should be useful and contains large amounts of information irrelevant to health professionals working in general practice and contraception clinics.

The vocabulary used is a mixture of medical and non-medical terms. For example, in the list of symptoms that might be identified are 'itch', 'dysuria' and 'superficial dyspareunia'. A professional term would be pruritus vulvae or vulval itching – otherwise this might mean itching anywhere (is it scabies?).

Contrast this Guideline with the one from the British Association for Sexual Health and HIV (BASHH) on bacterial vaginosis.[2] The BASHH Guideline gives the full explanation of the meaningless section in Table 31 where information has been compressed and says:

Nugent or Hay/Ison criteria:

- *Gardnerella and/or Mobiluncus* morphotypes predominant
- Score >6.

Table 3 does not give the full criteria, nor explain to what the score refers. By contrast, the example from the BASHH Guideline[2] is perfectly full and clear. However, as this is a bacteriological diagnosis made in the laboratory, why is the information supplied at all? Similarly, on page 38, why do we need to know: "Culture in Sabouraud's medium can be used to detect candida if microscopy is inconclusive …"? Readers will find other examples of superfluous and unnecessary information. The whole point was, I thought, to give a guideline to *clinicians* working in *non-GUM venues*.

Table 4 sets out clearly the options for treatment (although a definition of what constitutes recurrent infection would be helpful) but then recommends readers to consult an up-to-date *British National Formulary*. Why give the dosages in the first place, if the authors think (correctly) that you should check them out anyway?

There are just too many words! Throughout the document, the excessive use of words obscures the usefulness of the rest of the information.

The clear message of whether investigation is necessary or not is well presented in Figure 1 – but the information repeated under Boxes 2, 3 and 4. Why not just refer to the figure and remove the unnecessary text?

I fail to see why information presented in Box 5 is then repeated in the text below. Surely, readers are able to refer back with a sentence: "Investigation is indicated if any of the conditions listed in Box 5 are present". The addition of the small amount of qualifying information about the information in Box 5 then clarifies the statement. The same repetition of information in the summary boxes and in the text appears for almost every point.

This wordy style of writing fails one of the most important criteria for communication. The easier the text, the more understandable information can be transferred from writer to reader. A guideline is useless unless used.

I would propose that guideline writers should:

- Study the techniques of the Plain English Campaign[3]
- Attend a course on writing skills, or read a book on writing skills[4]
- Consult guidance on writing guidelines[5]
- Allow those guidelines published in the *Journal of Family Planning and Reproductive Health Care* to be edited in exactly the same way as all articles to maintain quality in the Journal.

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*References*

1 Faculty of Family Planning and Reproductive Health Care Clinical Effectiveness Unit. FFPRHC and BASHH Guidance (January 2006). The management of women of reproductive age attending non-genitourinary medicine settings complaining of vaginal discharge. *J Fam Plann Reprod Health Care* 2006; **32**: 33–42.
2 http://www.bashh.org/guidelines/2002/bv_0601.pdf [Accessed 23 January 2006].
3 http://www.plainenglish.co.uk/guides.html [Accessed 23 January 2006].
4 http://www.timalbert.co.uk/ [Accessed 23 January 2006].
5 www.jr2.ox.ac.uk/bandolier/painres/download/whatis/WhatareClinGuide.pdf [Accessed 23 January 2006].

## Reply

Thank you for the opportunity to respond to the letter from Prof. Gill Wakley about the joint FFPRHC/BASHH Guidance on 'The management of women of reproductive age attending non-genitourinary medicine settings complaining of vaginal discharge'.[1] As ever, the CEU welcomes constructive criticism from users of our various forms of Guidance. Prof. Wakley considered this guidance to be 'wordy' and generally unhelpful. It is always difficult, of course, to achieve the right balance of brevity and provision of adequate evidence to support our recommendations. In CEU Guidance, we highlight our explicit recommendations within coloured text boxes; this enables users who favour brevity to read the boxed text alone, without the supporting paragraphs.

This particular Guidance has been endorsed by both the FFPRHC and by BASHH. It has also been endorsed by the English Department of Health and NHS Quality Improvement Scotland to the extent that these organisations are funding wide distribution of the Guidance, in printed leaflet form, to general practices and other primary care settings. It is therefore clear that many individuals and organisations would not agree with Prof. Wakley's opinion of the document.

Prof. Wakley kindly provides suggestions on sources of training in writing skills that might be accessed by the CEU team. While accepting her criticisms, I might say that final editing of this Guidance was undertaken by myself in my capacity as Honorary Director of the CEU; I have over 120 peer-review publications and have been actively involved in national guideline development since 1992. CEU Guidance is reviewed by an expert group (comprised of up to 20 professionals), the FFPRHC Clinical Effectiveness Committee and the FFPRHC Officers prior to publication. Because of this extensive peer-review mechanism, our Guidance is not subject to the same editorial process as other submissions to the Journal. Prof. Wakely can perhaps understand that it is often our efforts to accommodate the views of so many stakeholders that result in Guidance documents being longer than we would like.

**Gillian Penney,** FRCOG, MFFP
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*Reference*

1 Faculty of Family Planning and Reproductive Health Care Clinical Effectiveness Unit. FFPRHC and BASHH Guidance (January 2006). The management of women of reproductive age attending non-genitourinary medicine settings complaining of vaginal discharge. *J Fam Plann Reprod Health Care* 2006; **32**: 33–42.

## Removing deep Implanon® implants

I would like to thank Martyn Walling for his very helpful paper[1] on removing deep Implanon®, which will enable other services to develop care pathways.

However, is it necessarily true, as stated in the last paragraph, that deep implants are evidently poorly inserted? This statement could have considerable medico-legal implications. The situation seems to me to be analogous to perforated intrauterine devices, which may be the result of poor technique but are normally defended as a recognised complication providing that proper counselling has been documented. Unless the Faculty offers support when there are problems after proper training it will be very difficult to encourage the use of implants, especially in general practice.

**Lesley Bacon,** MFFP, MRCGP
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*Reference*

1 Walling M. How to remove impalpable Implanon® implants. *J Fam Plan Reprod Health Care* 2005; **31**: 320–321.

## Reply

I do not think there is a medico-legal problem as there is a training programme in place with Implanon®. The major message with this article[1] is to encourage reviewing our own insertion technique. If the skin is tented properly so that the outline end of the needle can be seen there should be no problems with removal. Impalpable Implanons are now a recognised complication but if these occur I advise contacting Organon for advice.

**Martyn Walling,** FRCGP, FFFP
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*Reference*

1 Walling M. How to remove impalpable Implanon® implants. *J Fam Plan Reprod Health Care* 2005; **31**: 320–321.

## HIV and contraception

I would like the thank the authors for their interesting and timely article on contraception and HIV.[1]

In the section on hormonal contraception they make no comment upon a possible increase in cervical shedding of HIV in women using these methods, which has been mentioned in previous reviews.[2] Is it now considered that cervical shedding is not increased and thus hormonal contraceptives have no increased risk of transmission of the virus?

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*References*

1 Waters L, Barton L. Contraception and HIV: what do we know and what needs to be done? *J Fam Plann Reprod Health Care* 2006: **32**: 10–14.
2 Cates W. Use of contraception by HIV infected women. *IPPF Med Bull* 2001; **35**: 1–2.