severe subserosal inflammation without mucosal inflammation leading to the conclusion that the source was elsewhere within the abdomen or pelvis. It is speculative that this episode 4 years earlier might also have resulted from the long-term presence of her IUD. Pelvic actinomycosis normally begins as subacute or chronic disease, months or years before presentation.¹

The copper IUD devices marketed in the UK have licensed durations of 5, 8 or 10 years. In women aged under 40 years it is recommended they are changed according to licence. If inserted after the age of 40 years they may remain *in situ* until 1 year after the menopause if the last period (LMP) is over the age of 50 years, or 2 years after if the LMP is under the age of 50 years.² These recommendations are based on consensus opinion and acknowledge that insertion-related risks are minimised by reducing the frequency of IUD changes. National guidance places strong emphasis on when removal is safe from a contraceptive point of view.² There is no clear mention of the need for removal once the contraceptive action is no longer required, or of the risks of failing to do so. The frequency with which ALOs are reported in routine smears rises in a linear fashion with the duration of use of devices.³ ALOs are more common with certain types of IUD (e.g. Multiload®) and uncommon with the levonorgestrel intrauterine system.⁴ Pelvic actinomycosis is an uncommon and poorly understood condition, but has been recognised to complicate IUD use since the first report in 1973. However, *Actinomycetes* also normally reside in the female genital tract.²

We cannot provide any denominator data for the number of women in the catchment population with a long-term IUD, but the occurrence of a cluster of cases of serious intraperitoneal sepsis in a single hospital in a relatively short space of time is unusual. It is likely that single cases are not reported, or the association with the copper IUD overlooked, by surgeons and not fed back to those providing contraception services. When a pelvic mass or abscess, fever and other signs of infection are found in patients with a long-term IUD, pelvic actinomycosis should be considered. Awareness of this could usefully be increased among general surgeons and gynaecologists. We recommend that current guidelines be revised to include some emphasis on the importance of timely removal of an IUD, once its contraceptive properties are no longer required. Women should be made aware that long-term retention may rarely result in serious sepsis associated with pelvic abscesses and/or actinomycosis. There should be more emphasis on timely removal of an IUD early in the menopause. This is not included in existing professional guidance² and patient information leaflets.⁵

Mary Pillai, FRCOG, MRCPCH
Consultant Gynaecologist, Gloucestershire Hospitals NHS Trust, Cheltenham General Hospital, Sandford Road, Cheltenham, UK.
E-mail: mary.pillai@glos.nhs.uk

Maud Van de Venne, artsexamen Maastricht, MRCOG
Specialist Registrar, Gloucestershire Hospitals NHS Trust, Cheltenham General Hospital, Sandford Road, Cheltenham, UK

J Shefras, MRCOG, MFSRH
Consultant in Sexual Health and Reproductive Medicine, Gloucestershire Hospitals NHS Trust, Cheltenham General Hospital, Sandford Road, Cheltenham, UK

References

- 1 Lely RJ, van Es HW. Pelvic actinomycosis in association with an intrauterine device. *Radiology* 2005; **236**: 492–294.
- 2 Faculty of Sexual and Reproductive Healthcare Clinical Effectiveness Unit. FSRH Clinical Guidance (November 2007). Intrauterine contraception. <http://www.ffrhrc.org.uk/admin/uploads/CEUGuidance>

IntrauterineContraceptionNov07.pdf [Accessed 10 August 2008].

- 3 Chatwani A, Amin-Hanjani S. Incidence of actinomycosis associated with intrauterine devices. *J Reprod Med* 1994; **39**: 585–587.
- 4 Merki-Feld GS, Lebeda E, Hogg B, Keller PJ. The incidence of actinomycosis-like organisms in Papanicolaou-stained smears of copper- and levonorgestrel-releasing intrauterine devices. *Contraception* 2000; **61**: 365–368.
- 5 Family Planning Association (fpa). *Your Guide to the IUD*. London, UK: fpa, October 2007.

Reply

With regard to the four cases of serious pelvic infection described by Pillai *et al.*,¹ the Clinical Effectiveness Unit (CEU) acknowledges that long-term retention of an intrauterine device (IUD) is associated with infection and that the risk of actinomycotic pelvic abscess increases with duration of use. For this reason, Faculty of Sexual and Reproductive Healthcare (FSRH) Guidance recommends that an IUD is removed at the end of its licensed duration or when no longer required.² In women having an IUD inserted between the age of 40 years and the menopause, FSRH Guidance recommends that, based on expert opinion, the risk of infection in the 20 days following replacement of an IUD outweighs the risk of extending use until the menopause. In this situation IUD use can be continued until 1 year after the last menstrual period (LMP), or 2 years after the menopause if the LMP occurs under the age of 50 years.²

Interestingly, since being asked to respond on behalf of the CEU, a 70-year-old woman presented to my gynaecology clinic with vaginal discharge and an IUD that had been *in situ* for 30 years. The threads of the IUD were visible and the patient had attended her GP practice after the menopause for cervical smear tests. She claimed that she had asked the practice nurse about removal of the IUD but had been reassured that it was not causing any harm.

It is not clear how many IUD users retain their IUD after the menopause and what proportion of these women develops complications. However, the cases described by Pillai *et al.* highlight the potential for life-threatening infection and a lack of awareness of the need for IUD removal among some IUD users and health professionals. Current FSRH Guidance does not emphasise the need to advise patients about the importance of IUD removal when no longer required and about the potential risks of long-term IUD retention. We are grateful to Dr Pillai and colleagues for drawing this to our attention and we shall ensure that a recommendation to this effect is included in future updates of the Guidance on 'Contraception for Women Aged Over 40 Years' and 'Intrauterine Contraception'.

Case reports are a useful source of evidence where no other evidence exists. We would encourage others to report complications that are particularly rare, serious or associated with prolonged contraceptive use.

Louise Melvin, MRCOG, MFSRH
Director, FSRH Clinical Effectiveness Unit (CEU) and Consultant in Sexual and Reproductive Health, Sandyford, Glasgow, UK.
E-mail: louise.melvin@ggc.scot.nhs.uk

References

- 1 Pillai M, Van der Venne M, Shefras J. Serious morbidity with long-term IUD retention [Letter]. *J Fam Plann Reprod Health Care* 2009; **35**: 132.
- 2 Faculty of Sexual and Reproductive Healthcare Clinical Effectiveness Unit. FSRH Clinical Guidance (November 2007). Intrauterine contraception. <http://www.ffrhrc.org.uk/admin/uploads/CEUGuidance> IntrauterineContraceptionNov07.pdf [Accessed 18 January 2009].

IUS producing a TAC

I recently saw a very unusual patient in whom an intrauterine system (IUS) appeared to produce a trigeminal autonomic cephalgia (TAC).

The patient, a 39-year-old woman, was fortunate never to have had a headache until the events reported here. In early 2007, the patient started to complain of severe menorrhagia. Her periods were heavy and lasted 14 days, and necessitated the use of 15–20 sanitary pads a day. Tranexamic acid 1000 mg qds was tried initially for 8 weeks but the heavy bleeding continued. Next a therapeutic trial of norethisterone 5 mg tds was tried for many months resulting in a mild improvement. In desperation, the patient was referred to a gynaecologist who felt that the next step was to insert a levonorgestrel-releasing IUS. This was duly done. Within 6 hours of inserting the IUS the attacks started. All the patient's attacks (averaging 5–7 attacks/day) were similar. All were left sided and lasted 15–30 minutes. An attack started with pain to the side of the left eye that the patient described as unbearable, like the worst toothache ever. Associated with the pain was profuse tearing mainly from the left eye, although the pain was so bad the patient also cried with her right eye. Her palpebral fissure narrowed, her nose ran and her eye became pink. Her face felt strange and numb though painful. Touching her face, or brushing her hair or her teeth, did not trigger an attack. The attacks continued daily for 4 weeks until the patient came to see me.

As she entered the room, an attack started. Following the attack I removed the patient's IUS very easily and gave her a zolmitriptan nasal spray in case she had further attacks. I arranged to see her 7 days later, at which time she appeared to be a completely different person. She had suffered one further attack some 6 hours after the IUS was removed and so had used the nasal spray. After this her attacks had totally stopped. At that clinic visit, in order to help her menorrhagia, which still raged, I started the patient on norethisterone again. Eighteen months later she is still totally free of attacks, and although her bleeding is still very heavy, she is not prepared to even consider allowing me to reinsert an intrauterine device/system, with or without hormones. She says the pain was the worst pain she could ever imagine and as a result she would never, even for the purposes of research, have an IUS inserted again.

This woman appeared to develop a TAC, which approximated most closely to a cluster headache, though some attacks lasted only 15 minutes. It might be argued that it was not the IUS itself, but the hormone present in the IUS, which triggered the attacks, however this seems unlikely. The patient had already had very large doses of progestogen prior to IUS insertion with no ill effects and has also had large doses following IUS removal. The progesterone dose in the IUS is effective locally and is unlikely to have reached a high level after only 6 hours. Conversely, if the problem were the hormone in the IUS, its removal would be unlikely to cause the hormone level to decrease significantly in 6 hours.

In summary, on the face of it this would appear to be a simple case of a woman having an IUS inserted and developing a TAC, which was rapidly cured by removing the device. I would be delighted to discover if any of the Journal's readers have observed a similar case.

Susan L Lipscombe, MBChB, MRCP
Park Crescent New Surgery, Brighton, UK.
E-mail: suelipscombe1@ntlworld.com

Informed consent for IUD fitting

Perforation of the uterus is a rare complication of intrauterine device (IUD) fitting. It is quoted as occurring in up to 2 in 1000 IUD fittings.¹ Risk factors for perforation include previous caesarean section² and postpartum insertion up to 6 months after delivery.³

Perforation may occur during the sounding of the uterus or the device itself may perforate the uterus. This can lead to the device being free in

the abdominal cavity, necessitating removal by laparoscopy or laparotomy. Faculty Guidance tells IUD fitters that they should explain the risk of perforation to women considering an IUD and document this discussion in the clinical record. This fits with General Medical Council (GMC) guidance on informed consent.⁴

I dealt with a complaint from a woman who had a perforation of the uterus following an IUD change; this lady required laparoscopy to remove a missing IUD. The perforation was diagnosed at her IUD check, when the threads were found to be missing. Despite a clinical record showing "perf" followed by a tick this lady alleged that she had not been made aware of the risk of perforation and that if she had been aware she would not have had an IUD fitted.

Dealing with this complaint led me to review my own clinical practice and to seek the opinions of other IUD fitters. Using a questionnaire, 15 instructing doctors were asked about the manner in which they (1) explain perforation risk to women and their confidence doing this and (2) assess their patients' understanding of the risk of perforation.

These doctors all explained the risk of perforation to all women on their first IUD fitting but only 80% did on subsequent fittings. They commonly used an explanation along the lines of: "There is a small chance – 1 in a 1000 – of perforation. This means making a hole in the wall of the womb. This is not serious but if the IUD goes into the tummy outside the womb it has to be removed with keyhole surgery". An explanation such as this would meet GMC consent guidance (i.e. you must tell patients if an investigation or treatment might result in a serious adverse outcome, even if the likelihood is very small).⁴

Although 50% of doctors found perforation easy to explain only 20% felt that their patients had understood the risk of perforation. If this is the case then this would not meet guidance that "you should check that a patient understands the terms that you use, particularly when describing the seriousness, frequency and likelihood of an adverse outcome". No doctor felt that patients were deterred from having an IUD fitted by the risk of perforation. More than 50% of the doctors felt that they would like further training in the discussion of risk of perforation of the uterus and of explanation of risk in general.

It sometimes takes a review of everyday practice to identify a learning need. In this case it was prompted by a complaint from a woman who unfortunately did experience uterine perforation following an IUD change. All the doctors questioned did discuss the risk of perforation at a first IUD fitting but not all did at a subsequent IUD change. We should not assume that a woman will remember the potential complications of IUD fitting from a previous consultation.

The management of this particular complaint and the results of this survey have changed the way in which I discuss perforation risk with women, and I now incorporate this into a fuller explanation of how the device is introduced and why a problem might occur potentially leading to perforation.

Sue Stillwell, FRCOG, FFSRH

Associate Specialist in Sexual Health, Sexual Health Services @ Wheatbridge, Chesterfield, UK. E-mail: Susan.stillwell@derbyshirecountypct.nhs.uk

Stephen Searle, MFPH, FFSRH

Consultant, Sexual Health Services @ Wheatbridge, Chesterfield, UK

References

- 1 Faculty of Sexual and Reproductive Healthcare Clinical Effectiveness Unit. FSRH Clinical Guidance (November 2007). Intrauterine contraception. <http://www.fsrhc.org.uk/admin/uploads/CEUGuidanceIntrauterineContraceptionNov07.pdf> [Accessed 12 February 2009].
- 2 Farmer M, Webb A. Intrauterine device insertion related complications; can they be predicted? *J Fam Plann Reprod Health Care* 2003; **29**: 227–231.
- 3 Caliskan E, Ozturk N, Dilbaz BO, Dilbaz S. Analysis of risk factors associated with uterine perforation by intrauterine devices. *Eur J Contracept Reprod Health Care* 2003; **8**: 155.
- 4 General Medical Council. *Consent: Patients and Doctors Making Decisions Together*; paragraphs 32–34. 2008. http://www.gmc-uk.org/guidance/ethical_guidance/consent_guidance/index.asp [Accessed 12 February 2009].

LETTERS TO THE EDITOR

Letters to the Editor are welcome and generally should not exceed 600 words or cite more than five references. For comments on material published in the most recent issue of the Journal, correspondence should be received within 4 weeks of dispatch of that Journal to be in time for inclusion in the next issue. When submitting letters correspondents should include their job title, a maximum of two qualifications and their address(es). A statement on competing interests should also be submitted for all letters. Letters may be submitted to the Editor or the Journal Editorial Office (details on page 69).

Journal of Family Planning and Reproductive Health Care Statement on Duplicate (Redundant) Publication

The January 2003 issue of the *Journal of Family Planning and Reproductive Health Care* included an article entitled:

Underhill G, Hewitt G, McLean L, Randall S, Tobin J, Harindra V, *et al.* Who has chlamydia? The prevalence of genital tract *Chlamydia trachomatis* within Portsmouth and South East Hampshire, UK. *J Fam Plann Reprod Health Care* 2003; **29**(1): 17–20.

This article overlapped considerably with an article in the February 2003 issue of STI, namely:

Pimenta JM, Catchpole M, Rogers PA, Hopwood J, Randall S, Mallinson H, *et al.* Opportunistic screening for genital chlamydial infection: II: Prevalence among healthcare attenders, outcome, and evaluation of positive cases. *Sex Transm Infect* 2003; **79**: 22–27.

The reasons for this are complex and are detailed on the Committee On Publication Ethics (COPE) website (<http://publicationethics.org/annualreport/ombudsmansreports>). This does not reflect on the scientific validity of either paper.

Anne Szarewski, PhD, FFSRH

Editor-in-Chief, *Journal of Family Planning and Reproductive Health Care*

Visit the Faculty Website at www.fsrh.org