

Progesterone receptor modulators

The review¹ on 'Progesterone receptor modulators in gynaecological practice' in the April 2010 issue of the Journal is a valuable contribution to the available literature on a currently important subject.

In the section on 'Contraception' the authors have dealt at length with mifepristone. Since the latter is not licensed for postcoital contraception, it would have been appreciated if the authors had dealt with some salient features of the recently introduced second-generation selective progesterone receptor modulator, ulipristal acetate, which is licensed for postcoital contraception for up to 120 hours after unprotected sexual intercourse.

The primary mechanism of action is inhibition of ovulation, but alterations in the endometrium also have anti-implantation effects.² Ulipristal acetate appears to be a more potent inhibitor of ovulation than levonorgestrel and hence may be relatively more effective as a method of postcoital contraception.³⁻⁵

While the post-implantation use of levonorgestrel has not been associated with any harm to an early pregnancy, as yet the same has not been established for ulipristal acetate.⁶

Ruzva Bhathena, FRCOG, FFSRH

Consultant Obstetrician and Gynaecologist, BD Petit Parsee General and Masina Hospitals, Bombay, India. E-mail: rkbhathena@gmail.com

References

- 1 Wilkens J, Critchley H. Progesterone receptor modulators in gynaecological practice. *J Fam Plann Reprod Health Care* 2010; **36**: 87-92.
- 2 Faculty of Sexual and Reproductive Healthcare Clinical Effectiveness Unit. New Product Review (October 2009). *Ulipristal Acetate (ellaOne®)*. <http://www.fsrhc.org.uk/admin/uploads/ellaOneNewProductReview1009.pdf> [Accessed 4 May 2010].
- 3 Croxatto HB, Brache V, Cochon L, Jesam C, Salvatierra AM, Levy D, et al. The effects of immediate pre-ovulatory administration of 30 mg ulipristal acetate on follicular rupture. Proceedings of the Eighth Congress of the European Society of Gynaecology, Rome, Italy, 10-13 September 2009.
- 4 Croxatto HB, Brache V, Pavaz M, Cochon L, Forcelledo ML, Alvarez F, et al. Pituitary-ovarian function following the standard levonorgestrel emergency contraceptive dose or a single 0.75 mg dose given on the days preceding ovulation. *Contraception* 2004; **70**: 442-450.
- 5 Cameron S, Glasier A. The need to take a 'new look' at emergency contraception. *J Fam Plann Reprod Health Care* 2010; **36**: 3-4.
- 6 Pittrof R, Rubenstein P, Sauer U. LNG may still be the best oral EC option (Letter). *J Fam Plann Reprod Health Care* 2010; **36**: 105.

Reply

We thank Dr Bhathena¹ for his interest in our recent review article.² The purpose of the review was to highlight the many different indications in gynaecological practice, in which progesterone receptor modulators (PRMs) may be applied and to focus on the potential health benefits of PRMs. PRMs have an endometrial antiproliferative effect in the presence of follicular phase estrogen levels, and this constitutes the basis of many of their potential advantages in the management of gynaecological conditions.

Currently, the only licensed indications for PRMs [mifepristone for termination of pregnancy and ulipristal (UPA) for emergency contraception (EC)] both relate to fertility control. Ulipristal has only recently received a licence based on good evidence regarding its effectiveness for EC even when taken up to 120 hours after intercourse.^{3,4}

This Journal has previously published very informative commentaries and correspondence on the topic of UPA in emergency contraception.⁵⁻⁷ Like other PRMs, UPA is associated with suppression of ovulation and menstruation via an effect, which may not be explained merely by progesterone antagonism.^{8,9} Registration of UPA followed the publication of the UPA trial and meta-analysis in the *Lancet* paper.³ The authors of this paper pointed out that regarding the mechanism of action, an effect of

UPA on the endometrium could not be ruled out although the effect on ovulation inhibition is potent. With respect to any potential harmful effect on pregnancy, it is reassuring to note that the rate of miscarriage between women treated with levonorgestrel and UPA for EC was not different.

Hilary Critchley, MD, FRCOG

Consultant, University of Edinburgh Centre for Reproductive Biology, Queens Medical Research Institute, Edinburgh, UK.

E-mail: Hilary.Critchley@ed.ac.uk

Julia Wilkens, MRCOG

Specialist Registrar, University of Edinburgh Centre for Reproductive Biology, Queens Medical Research Institute, Edinburgh, UK.

E-mail: Julia.Wilkens@ed.ac.uk

References

- 1 Bhathena R. Progesterone receptor modulators (Letter). *J Fam Plann Reprod Health Care* 2010; **36**: 179.
- 2 Wilkens J, Critchley H. Progesterone receptor modulators in gynaecological practice. *J Fam Plann Reprod Health Care* 2010; **36**: 87-92.
- 3 Glasier AF, Cameron ST, Fine PM, Logan SJ, Casale W, Van Horn J, et al. Ulipristal acetate versus levonorgestrel for emergency contraception: a randomised non-inferiority trial and meta-analysis. *Lancet* 2010; **375**: 555-562.
- 4 Fine P, Mathe H, Ginde S, Cullins V, Morfesis J, Gainer E. Ulipristal acetate taken 48-120 hours after intercourse for emergency contraception. *Obstet Gynecol* 2010; **115**(2 Pt 1): 257-263.
- 5 Cameron S, Glasier A. The need to take a 'new look' at emergency contraception. *J Fam Plann Reprod Health Care* 2010; **36**: 3-4.
- 6 Pittrof R, Rubenstein P, Sauer U. LNG may still be the best oral EC option (Letter). *J Fam Plann Reprod Health Care* 2010; **36**: 105-106.
- 7 Mansour D, EllaOne: a second-generation emergency contraceptive? *J Fam Plann Reprod Health Care* 2009; **35**: 217-218.
- 8 Chabbert-Buffet N, Pintiaux-Kairis A, Bouchard P. Effects of the progesterone receptor modulator VA2914 in a continuous low dose on the hypothalamic-pituitary-ovarian axis and endometrium in normal women: a prospective, randomized, placebo-controlled trial. *J Clin Endocrinol Metab* 2007; **92**: 3582-3589.
- 9 Brenner RM, Slayden OD, Nath A, Tsong YY, Sitruk-Ware R. Intrauterine administration of CDB-2914 (Ulipristal) suppresses the endometrium of rhesus macaques. *Contraception* 2010; **81**: 336-342.

Nurse training in SRH

I have just read the Personal View¹ on 'Nurse training in SRH' in the January 2010 issue of the Journal and I agree with most of what Shelley Mehigan and her colleagues have written.

It would seem sensible that sexual and reproductive healthcare (SRH) training is unified for doctors and nurses. Full membership of the Faculty of Sexual and Reproductive Healthcare (FSRH) should be open to both. Nurse practitioners should be allowed to undertake the same training and sit for the Letters of Competence (LoCs), Diploma of the FSRH (DFSRH) and Membership of the FSRH (MFSRH). SRH, in particular, is ideally suited for such progress. Increasingly, nurse practitioners are providing Level 1 and Level 2 services and doing the bulk of the routine clinical work.

The Mehigan *et al.* article did not mention that several Colleges already allow other health care practitioners to undertake their training and examinations. I am sure that readers are well aware of this; here are some good examples.

1 Faculty of Public Health of the Royal Colleges of Physicians

Other health care professionals, in addition to doctors, may undertake the full training in public health and then be placed on the Voluntary Register of Public Health Specialists. They can take the MPPH (Membership of Public Health) examination. They may be appointed as Consultants in Public Health and interestingly can act as Leads in SRH.

2 Royal College of Pathologists

Training and Membership of the Royal College of Pathologists (MRCPATH) is open to scientists, such as virologists and biochemists, and they are

not necessarily required to have a medical qualification.

3 Royal College of Surgeons of Edinburgh

The DIMC (Diploma in Immediate Medical Care) of the Royal College of Surgeons of Edinburgh is open to doctors, nurses and paramedics working in this field.

4 Society of Apothecaries

The DFCASA (Diploma in the Forensic and Clinical Aspects of Sexual Assault) is open to nurses and midwives as well as doctors. This particular diploma is very relevant to SRH practice. The DMCC (Diploma in the Medical Care of Catastrophes) is also open to nurses as well as doctors.

5 University diplomas

Many of the University diplomas are open to a wide range of health care professionals [e.g. the Diploma in Palliative Care of Cardiff University (nurses, doctors) and the Diploma in Medical Law of Northumbria University (nurses, managers, lawyers, doctors)].

6 Medical Royal Colleges and Nurse Training

There should be no great impediment to the Medical Royal Colleges working more closely together with the RCN and universities on unified nurse and doctor training in shared fields.

The Royal Charter of the Royal College of Obstetrician and Gynaecologists (RCOG) (1947) states the purpose is: "The encouragement of the study and the advancement of the science and practice of obstetrics and gynaecology". This is a broad definition and should allow the RCOG and the FSRH to take a progressive view of joint training.

In conclusion, I fully support the Personal View article and would be happy to discuss it further with the authors. I will also be interested to hear about future progress on this issue.

Vincent Argent, FRCOG, MFSRH

Consultant Obstetrician and Gynaecologist, Defence Medical Services, UK.

E-mail: vincent_argent@hotmail.com

Reference

- 1 Mehigan S, Moore W, Hayes L. Nurse training in sexual and reproductive health. *J Fam Plann Reprod Health Care* 2010; **36**: 5-6.

Need for IUD fitters to have expertise in resuscitation

I was pleased to read the Personal View¹ article on 'Nurse training in SRH' in the January 2010 issue of the Journal.

We have a related issue at the moment and would welcome comment from other Journal readers. It concerns the Faculty's guidance on resuscitation for nurses when fitting IUDs.² It suggests someone competent to give intravenous (IV) drugs must be available. The Royal College of Nursing (RCN) has also made a statement³ supporting this but when contacted the RCN said it supported it because it was Faculty guidance and didn't seem to understand the consequences or practicalities. It would appear that there is no named person to discuss this matter with there.

We currently have nurse-led community clinics that provide intrauterine devices/intrauterine systems (IUDs/IUSs) with no doctor present. Indeed we have very few doctors in such clinics.

None of us have ever cannulated or given IV drugs (including me for over 20 years). Some people have taken blood from time to time but none of us have any need to do so regularly. We are advised that to be competent to do so would involve weekly IV drug administration/cannulation, which would remove us all from clinic to theatre or similar to do so. Our resuscitation department is amazed by the guidance.

We surely cannot be the only family planning unit that has predominantly nurse-led clinics, and I cannot believe all IUD fitters have extensive

experience at IV administration. Perhaps we are unusual in that so many of our nurses do so many procedures.

Do any readers know of anyone else who is struggling with this issue? I have talked to one or two colleagues who were totally unaware of this guidance but I thought some of the Journal's readers might be.

Barbara Hollingworth, FFSRH, DRCOG
Consultant in Family Planning and Sexual Health, Barking, Havering and Redbridge University Hospitals NHS Trust, UK.
E-mail: bah@lupins.plus.com

References

- 1 Mehigan S, Moore W, Hayes L. Nurse training in sexual and reproductive health. *J Fam Plann Reprod Health Care* 2010; **36**: 5–6.
- 2 Faculty of Sexual and Reproductive Healthcare. *Service Standards for Resuscitation in Sexual Health Services*. July 2006. <http://www.fsrh.org/admin/uploads/ServiceStandardsResuscitationSHServices.pdf> [Accessed 14 January 2010].
- 3 Royal College of Nursing (RCN) Statement.

Nurse training and the need for IUD fitters to have expertise in resuscitation

I felt I had to put fingers to keyboard after reading the thoughtful Personal View by Shelley Mehigan and her colleagues¹ along with the subsequent correspondence in the April 2010 issue of the Journal.

Nurse training in our specialty needs a nationally recognised and standardised educational pathway² producing health care professionals who are 'fit for purpose'. This training must be theoretically and practically robust, be based on sound evidence and the accreditation must not be overly expensive. Our services may still be 'doctor-led' in many parts of the UK, but clinics would come to a grinding halt if nurses are restricted in their practice and become 'handmaidens' once more. The letter written by Dr Barbara Hollingworth³ clearly illustrates this point.

We have also had local community nurse-based clinics fitting intrauterine contraceptives in general practice premises suspended because 'doctor cover' by the general practitioners [who can administer intravenous (IV) drugs] has been withdrawn. Faculty guidance in Service Standards for Resuscitation⁴ and Intrauterine Contraception⁵ does not clearly state that a health care professional proficient in giving IV drugs is available on site but this is implied by having atropine (0.6 mg/ml) available for IV use. Clinical Leads should check with their local Ambulance Trusts as many suggest that adrenaline is the only drug that needs to be available within community clinics.

I have recently asked over 70 health care professionals who fit intrauterine contraceptives about their use of atropine and no one has administered it. I have on one occasion in the last 22 years when a woman was very keen to keep an intrauterine device (IUD) in situ as she felt it was her only contraceptive option. On all other occasions when faced with vasovagal attacks or persistent bradycardias women have recovered by applying basic life support measures including the removal of the IUD device where necessary.

Perhaps when both these documents^{4,5} are reviewed this issue will be clarified.

Diana Mansour, FRCOG, FFSRH
Clinical Director, Sexual Health Services, NHS Newcastle and North Tyneside, Community Health, Newcastle upon Tyne, UK.
E-mail: Diana.Mansour@newcastle-pct.nhs.uk

References

- 1 Mehigan S, Moore W, Hayes L. Nurse training in sexual and reproductive health. *J Fam Plann Reprod Health Care* 2010; **36**: 5–6.
- 2 Mehigan S, Moore W. Authors' response to

correspondence about Nurse Training in SRH (Letter). *J Fam Plann Reprod Health Care* 2010; **36**: 111.

- 3 Hollingworth B. Need for IUD fitters to have expertise in resuscitation (Letter). *J Fam Plann Reprod Health Care* 2010; **36**: 179–180.
- 4 Faculty of Sexual and Reproductive Health Care. *Service Standards for Resuscitation in Sexual Health Services*. July 2006. <http://www.fsrh.org/admin/uploads/ServiceStandardsResuscitationSHServices.pdf> [Accessed 9 May 2010].
- 5 Faculty of Sexual and Reproductive Health Care Clinical Guidance. Clinical Effectiveness Unit. *Intrauterine Contraception*. November 2007. <http://www.fsrh.org/admin/uploads/CEUGuidanceIntrauterineContraceptionNov07.pdf> [Accessed 9 May 2010].

Reply

I would like to thank Drs Hollingworth and Mansour for their letters about nurse training and the need for intrauterine device (IUD) fitters to have expertise in resuscitation.^{1,2} This is a question that I am being increasingly asked by clinicians around the country as they become aware of the implications of recent guidance on this topic. Not only is it unrealistic to expect all the clinicians involved to undertake the extra training and regular practice to comply with the guidance – looking at the British Resuscitation Council guidelines,³ doing what is advised would need advanced life support (ALS)-level training with regular practice of the techniques – it also has implications for how services can be delivered not just by nurses but by doctors too. Many services will feel it is unworkable. Those that have tried, like Dr Hollingworth, to ask the Royal College of Nurses (RCN), have been referred to the Faculty guidance,⁴ and the Faculty rightly feel that they were following advice from the RCN.

As I understand it, the original guidance from the RCN,⁵ which was directed at nurses fitting devices rather than assisting other clinicians and was based on discussions with the RCN legal team, advised that nurses should make a local risk assessment based on how often they felt a problem might arise? Would we insist on the same restrictions for doctors fitting an IUD/implant?

Why might we treat nurses differently?

Issues to consider include:

- Should the nurse fit an IUD very late in the evening?
- If the woman has had a difficult fitting in the past?
- Is there a need to have another registered practitioner (nurse or doctor) in clinic?
- If a woman had rushed in and had not eaten for hours, and so on?

Perhaps the way forward would be for one or more groups at the Faculty to produce guidance for use by all clinicians to follow in such scenarios. This would reflect the multidisciplinary aspect of the work and recognise that this could apply to either doctors or nurses, both groups having highlighted that this is an area where few currently feel able to undertake the actions suggested in the current guidance. If this guidance could be produced following discussion with experts in the field of resuscitation it would then hopefully be realistic, as well as being practical, and would reflect current evidence-based best practice.

Shelley Mehigan, RGN

Nurse Specialist (Contraception), Berkshire East Community Health Services, Sexual Health, Upton Hospital, Slough, UK.
E-mail: shelley.mehigan@berkshire.nhs.uk

References

- 1 Hollingworth B. Need for IUD fitters to have expertise in resuscitation (Letter). *J Fam Plann Reprod Health Care* 2010; **36**: 179–180.
- 2 Mansour D. Nurse training and the need for IUD fitters to have expertise in resuscitation (Letter). *J Fam Plann Reprod Health Care* 2010; **36**: 180.
- 3 British Resuscitation Council guidelines.
- 4 Faculty of Sexual and Reproductive Health Care. *Service Standards for Resuscitation in Sexual Health*

Services. July 2006. <http://www.fsrh.org/admin/uploads/ServiceStandardsResuscitationSHServices.pdf> [Accessed 9 May 2010].

- 5 Royal College of Nursing (RCN) Statement.

Safe sex during pregnancy

As a consultant in genitourinary medicine, I wish to comment on Box 1 entitled 'Is it safe to have sex?' in Susan Quilliam's Consumer Correspondent article¹ in the April issue of the Journal.

The second point made is that "if either partner has a sexually transmitted infection (STI), they should use protection ...". If one of a couple has an STI then it is generally recommended that for a treatable infection a couple desist completely from having any penetrative sex until treatment of both partners is complete. Condoms do not provide 100% protection against any STI and any untreated infections in pregnancy can carry serious consequences.

I am uncertain why protected anal sex should be "avoided altogether". If the couple exercises good hygiene practice is there any other concern about such a practice in regard to pregnancy? I could not find anything in the article to explain this advice.

Susan Young, FRCPI, FRCP

Consultant in Genitourinary Medicine, Sherwood Forest Hospitals NHS Foundation Trust, King's Mill Hospital, Sutton in Ashfield, UK. E-mail: Susan.Young@sffh-tr.nhs.uk

Reference

- 1 Quilliam S. Sex during pregnancy: Yes, Yes, Yes! *J Fam Plann Reprod Health Care* 2010; **36**: 97–98.

Reply

First, I wish to thank Dr Young for reading my article¹ so carefully and responding to it so thoughtfully in her letter.²

Dr Young is, of course, correct that if either partner in a couple has a sexually transmitted infection (STI) they should ideally not have sex at all until after treatment. However, in practice this advice is frequently ignored – particularly during pregnancy when partners want to reinforce their bond and reflect their closeness – so I was being pragmatic in advising protection.

Similarly, Dr Young is correct in saying that in ideal circumstances, anal sex is safe. But in the 'real life' situations that I hear about, hygiene practices around anal sex are often far from perfect and so, again pragmatically, during pregnancy in particular I generally advise avoidance.

Finally, the aim of my article, and the substance of the main body of my text, was to promote sex in pregnancy and ask professionals to encourage it. I didn't aim to give detailed information about risks – such information is covered fully in many other sources. Hence the guidance provided in the summary boxes gives headlines only rather than explaining in full the medical background.

Susan Quilliam, BA, MNLP

Freelance Writer, Broadcaster and Agony Aunt, Cambridge, UK.
E-mail: susan@susanquilliam.com

References

- 1 Quilliam S. Sex during pregnancy: Yes, Yes, Yes! *J Fam Plann Reprod Health Care* 2010; **36**: 97–98.
- 2 Young S. Safe sex during pregnancy (Letter). *J Fam Plann Reprod Health Care* 2010; **36**: 180.

e-SRH e-Learning

As an Instructing Doctor for the Faculty of Sexual and Reproductive Health Care (FSRH), I have enjoyed completing this online training¹ at www.e-lfh.org.uk.

This is an excellent course, and the animations, including the physiology of the