

system in 1995. I use dental cartridges containing prilocaine 3% and felypresin 0.03 IU/ml (branded as Citanest® with Octapressin). This is delivered via a breech loading dental syringe with a 27 G 35 mm screw fit needle. This anaesthetic offers rapid onset and low cardiovascular toxicity, and I can report no episodes of true tachyarrhythmia or perceived palpitations over this time. I have used plain mepivacaine 3% when the preferred preparation has been unavailable and this appears to be less well tolerated. I have never used lidocaine but would be instinctively cautious if using this drug in a highly vascular organ.

The dental needle is very fine and the sensation felt by the woman at insertion is described as peculiar rather than painful. After insertion along the axis of the cervix, half of the capsule is delivered as a bolus at the depth of the needle (this is the level of the internal os). I would disagree with Dr Devonald and report that this does effectively anaesthetise and prevent spasm of the internal os. Where there is true stenosis some discomfort but no more is felt on delivering the initial bolus, but this allows for gentle dilatation. The other half of the capsule is infiltrated on withdrawal through the cervix.

For most women two injections, one at each of 3 and 9 o'clock are sufficient but very rarely an additional capsule is needed and is usually delivered at full depth at the 12 o'clock position. If at all possible the injections are delivered before applying a tenaculum, but a very mobile cervix may require the tenaculum to be applied first or after the first injection to ensure that the second reaches the internal os. A previous failed insertion by an experienced fitter would on rare occasions indicate four injections at 2, 4, 8 and 10 o'clock at the outset.

For recently parous women having had a vaginal delivery I find that local anaesthesia (LA) is rarely needed. However, even in that scenario the very anxious patient may choose to ensure that pain is minimised. Anxiety very obviously exacerbates spasm of the circular muscle of the cervix and I contend that women who recognise their own fears can be allowed to accept an option to prevent this. In all women we allow a free choice with sufficient information to make a decision, offering lidocaine gel as the alternative to reduce the discomfort of tenaculum application. I am not convinced this has any other than placebo influence at the internal os.

Women who have not had a vaginal delivery, women attending for replacement of IUDs and women in their late-40s have more directed counselling and are told that LA is recommended but that we are perfectly happy to proceed without and stop if it hurts.

### Option of local anaesthetic for IUD fittings

Following the correspondence on the subject in this Journal,<sup>1,2</sup> I write to support the position that women should be offered the option of local anaesthetic for intrauterine device (IUD) fittings and allowed to make a guided but informed decision.

I have been offering intracervical anaesthesia to women since the introduction of the levonorgestrel intrauterine

I fit IUDs in general practice settings and in a women's health and menopause clinic but have only a standard electric couch. I potentially see higher proportions of women who are older, have heavy menstrual bleeding or are in need of endometrial opposition than most. I would estimate that two-thirds of my women opt for injectable anaesthesia and a few of the others ask for it during the procedure. Almost universally, these women report that their experience was much easier than they had feared and would recommend it to their friends.

I teach both my experienced general practitioner colleagues and new trainees (including nurses) how to use LA and most are happy to undertake the procedure. They report that it relieves their anxieties as well as those of their patients and for the previous fitters it transforms their clinical practice. Their practice nurses have reported informally that they are now much happier to recommend IUDs to women as they feel that the fitting is not going to be traumatic.

I would suggest that if we have a means of reducing pain in an elective procedure then it is unethical for this not to be offered if appropriate. I would, however, also suggest that consideration is given to the choice of anaesthetic used.

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