Service standards for sexual health

Madam

We fail to understand why Dr Stephen Searle feels that implementing the service standards for sexual health is detrimental to, and an integral part of, patient care. To view it as reactive bureaucracity, which is only necessary to protect in cases of legal action for poor practice, is surely to miss the point. Rather, good record keeping is a fundamental part of each episode of patient care.

Clear formalisation of standards is a rapidly developing area. The documents produced by the National Service Standards on Intimate Branch of the Clinical Standards Committee have short review cycles so that views can be included commensurate with this progression. Further, the committee and reviewers are eager to receive comments and suggestions. It is to be hoped that these will inform the refinement of the standards at review thus maximising their usefulness.

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References
1 Searle S. Service standards for sexual health (Letter).

IUD insertion following medical TOP

Madam

We found the FFPFRHC Guidance on ‘The copper intrauterine device as long-term contraception’ informative but were surprised by the lack of data relating to intrauterine device (IUD) insertion following medical termination of pregnancy (TOP) (Section 26). Our data show that more than 300 medical TOPs annually up to 83 days’ gestation. All women are screened for sexually transmitted infections and there is a 96% complete miscarriage rate. The proportion of cases that either abortion occurs or completes at home in the first few days following the administration of misoprostol. If the patient is not happy with her choice, the above steps are repeated. The intrauterine contraception such as oral contraceptive or Depo-Provera® is commenced immediately by the nursing staff. Women are then reviewed in a weekly specialist family planning clinic approximately 7–10 days after their termination procedure. This review ensures that the termination is complete and allows the patient’s physical and emotional status to be assessed. IUDs or implants are inserted at this visit. Occasionally at this appointment bleeding is still continuing and further misoprostol is required to expel all products of conception. Another appointment is then made 1 week later for the IUD insertion. Since January 2000, 55 copper IUDs have been inserted between 4 and 30 (average, 11) days following medical TOP. The majority were Gyne T380® or NovaTec copper IUDs but included two GyneTec® IUDs in 2000 and two Flexi-T33® IUDs in 2003. The two women whose copper IUDs were fitted at another hospital performed the insertion. One subsequently miscarried and the other conceived without incident. Two women have conceived with copper IUDs in situ and 4 and 6 months after insertion. The first trimester postabortal uterus does not appear to behave like a postpartum uterus. In practice many women would not wish to be examined within the first 48 hours when the bleeding is heavier and in some women the uterus may not be completely empty. Waiting for 4 weeks (presumably until after the next menses) requires women to arrange a further appointment that they may have difficulty keeping and also denies them efficient contraception for the first month after TOP.

We suggest that a review appointment, usually at 7–10 days post-medical TOP, allows safe insertion of both copper IUDs and Mirena IUS and should be promoted.

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References

Reply

Madam

The FFPFRHC Clinical Effectiveness Unit (CEU) provides evidence-based Guidance documents on women’s health service and reproductive healthcare topics. The recent Guidance document ‘The intrauterine device as long-term contraception’ was developed using best available evidence from a systematic literature review and collective knowledge of the multidisciplinary expert group and subsequent peer review. Despite a large number of medical abortions performed each year in England, Wales and Scotland, there is a lack of published evidence on the timing of intrauterine contraceptive insertion following medical abortion. The insertion of intrauterine contraception immediately following abortion clearly has advantages. The insertion of intrauterine contraception at the time of surgical abortion is practical and safe.7 The World Health Organization (WHO) listOf Eligibility Criteria for Contraceptive Use (WHOMEC) recommends that intrauterine contraception can be inserted immediately following induced or spontaneous first-trimester abortion (WHO 1: unrestricted use). Although the risk of expulsion of an intrauterine device (IUD) following second-trimester abortion is increased,2 WHO recommends that benefits still outweigh the risks (WHO 2.3). Although WHOMEC does not provide recommendations regarding insertion of intrauterine contraceptive use, evidence from case-control studies showed low perforation rates with insertion within 30 days of abortion.

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20 days after insertion and a new IUS was refitted without incident. Two women have conceived with copper IUDs in situ for 4 and 6 months after insertion. The first trimester postabortal uterus does not appear to behave like a postpartum uterus. In practice many women would not wish to be examined within 48 hours after abortion for weeks for women undergoing first-trimester medical TOP is too restrictive. The first trimester postabortal uterus does not appear to behave like a postpartum uterus. In practice many women would not wish to be examined within a few days when the bleeding is heavier and in some women the uterus may not be completely empty. Waiting for 4 weeks (presumably until after the next menses) requires women to arrange a further appointment that they may have difficulty keeping and also denies them efficient contraception for the first month after TOP.

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Journal of Family Planning and Reproductive Health Care 2004; 30(3)