HIV and contraception
Thank you for publishing the article on HIV and contraception in the January issue of the Journal. The advice was succinct and helpful. I would just like to add my support to it. Namely, that all effective methods of contraception will reduce the spread of HIV in a population. This is achieved by reducing the number of couples with the possibility of mother-to-child transmission during pregnancy.

Karen Trevinnard, BM, MFPP
Ship’s Doctor, MV Duplos, Alte Neckarleuter Strasse2, 74821 Mosbach, Germany. E-mail: Karen.Trevinnard@MVDUPOLOS.ORG

Reference

LETTERS
HIV and contraception
I read with great interest the review by Drs Waters and Barton on contraception and HIV. The position is clear in HIV-discordant couples (i.e. where one partner is HIV negative) and the consensus has rightly concluded that a barrier contraceptive should be combined with another method of contraception when advising these couples. The risk of horizontal transmission with each unprotected act of intercourse is difficult to quantify as it is dependent on a number of factors including stage of HIV infection, route of antiretroviral treatment, and presence of local infection. Moreover, the risk of HIV transmission is significantly increased in either or both the HIV-infected and uninfected partner has another sexually transmitted infection.

As regards HIV concordant couples, there is a possibility of transmission of resistant virus. Therefore these couples should also be strongly encouraged to avoid unprotected intercourse and use a reliable barrier method of contraception in addition to another method of contraception.

I would be grateful for the author’s thoughts on this matter.

Shaur K Qureshi, MBChG, DFFP
Senior House Officer, Department of Obstetrics and Gynaecology, Nobles Hospital, Strang Braidan, Isle of Man IM4 4RJ, UK

Reference

Nurse prescribing
As a group of extended nurse prescribers working in the field of contraception and sexual health we are aware of concerns about the limitations of not being able to prescribe contraception outside the terms of the product licence.

Nurse prescribers should not currently prescribe medicines independently for uses outside their licensed indications, and that this decision has been subject to consultation and that the Medicines and Healthcare Regulatory Agency (MHRA) will be considering responses before putting them to the Committee on Safety of Medicines in the Autumn. However, we feel that much prescribing in the field of contraception is off licence, so much so that the FP10HC guidance on this topic1 (July 2005) covers 17 pages!

Many summary product characteristics (SPC) sheets are so out of date that the patient information leaflets provide women with information which conflicts with alternative evidence-based sources of patient information such as the fpa (Family Planning Association) leaflets. Examples of the impact this has on our practice include the following. We cannot advise a woman to start her pill later than Day 1. We cannot apply the criteria for being ‘reasonably certain’ a woman is not pregnant so as to allow >5 days start of the combined oral contraceptive (COC). We cannot advise tri-cyclics to prevent withdrawal bleed, reduce menstrual bleeding problems, premenstrual symptoms, or to avoid withdrawal headaches.

We cannot recommend a shortened pill-free interval for women with a true pill failure, or for those on liver enzyme-inducers. Likewise we cannot prescribe low-dose COCs to give 50 μg for women on liver enzyme-inducers. We cannot increase the doses of emergency hormonal contraception (COCs) for women on liver enzyme-inducers. We cannot offer progestogen-only emergency contraception beyond 72 hours. We cannot offer EHC more than once per cycle. We cannot ‘quick start’ COC following EHC. We cannot offer a short course of COC/progestogen-only pill for women experiencing initial bleeding problems with an implant.

There are many other situations where best practice would allow our medical colleagues to prescribe out of licence. The above examples of out-of-licence prescribing do not constitute any increased risk to the patient and would all be implemented following careful and detailed assessment and would be in the women’s best interest.

Nurse prescribers, working in the area of contraception, want to provide women, of all ages, with optimum care, which is being compromised by outdated SPCs. We hope that the MHRA will apply common sense and reason to their decisions relating to this important area of health care.

Sue Williams, RGN
Clinical Nurse Specialist and Sexual Health Service, Eastington PCT, Centre for Health, Whitehouse Business Park, Petterel SR8 2RT, UK. E-mail: Sue.williams@eastingtonpct.nhs.uk

Reference