LETTERS

HIV and contraception

Thank you for publishing the article on HIV and contraception1 in the January issue of the Journal. The advice was succinct and helpful. I would just like to comment otherwise. Namely, that all effective methods of contraception will reduce the spread of HIV in a population. This is achieved by reducing the frequency for mother-to-child transmission during pregnancy.

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Reference

HIV and contraception

I read with great interest the review by Drs Waters and Barton on contraception and HIV.1 The position is clear in HIV-discordant couples (i.e. where one partner is HIV negative) and the couples have rightly concluded that a barrier contraceptive should be combined with another method of contraception when advising these couples. In the case of high-risk 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, response to antiretroviral treatment, and presence of local infection.2 Moreover, the risk of HIV transmission is significantly decreased in the either the HIV-infected and uninfected partner has another sexually transmitted infection.3 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.2

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

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Reference

Reply

We would like to thank the respondents to our recent article1 for their comments.

With regard to Qureshi’s comments on transmission of resistance virus between sero-concordant couples, we agree that the use of barrier contraception in addition to other methods should be advised. Although, in practice, super-infection with new viral strains is uncommon, independent viral replication in the genital tract means one cannot rely on plasma viral load as a marker of risk for unprotected sexual intercourse. Additional factors such as the presence of concurrent sexually transmitted infections may increase viral shedding and transmission.

With regard to Robinson’s comments on the association between hormonal contraception and cervical shedding of virus, the evidence is contradictory. We would normally counsel the judicious use of effective contraception will indeed reduce HIV transmission by the mother-to-child transmission route.

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Reference

Nurse prescribing

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

We cannot advise our patients on hormonal contraception before they know and what needs to be done1. J Fam Plann Reprod Health Care 2006; 32: 10–14.

Nurse prescribing

I was disappointed and somewhat dismayed to read the article on ‘Nurse prescribing in family planning’ in the January 2006 issue of the Journal.

As an extended independent nurse prescriber since 2002, I believe the implementation of the extended formulary has been the single most important factor in my development and enhancement for skill and experienced nurses within the specialty.

Young bemoans the fact that a challenging course of education and assessment is required before nurses can take on this role, and believes that by dint of being an ‘unknown quantity’ nurses are at risk of being challenged by their medical colleagues. I, however, would disagree. As an extended independent nurse prescriber with significant clinical experience working in the field of contraception and sexual health we believe nurses have the same level of knowledge and skills to assess and treat our patients. However, legitimising this activity has recognised this, and given these experienced nurses the opportunity to use those skills, enhance their practice and, importantly, accept responsibility for their decisions and actions. We no longer require the rubber stamp of the doctors’ signatures to endorse our actions (and how many times in the past were nurses frustrated by doctors’ refusal to take part in the process) and that the nurse appears to be advocating a return to the bad old days, when nurses were dependent on the good will of their medical colleagues to ‘allow’ them to unofficially prescribe, and to carry the can if wrong decisions were made.

Ms Young’s frustration at the pharmacist’s refusal to comply with her request for her friend’s signature is perhaps understandable. However, I suspect most pharmacists would be reluctant to accept a direction from an unknown person over the telephone; although in my experience, most will in fact sell a single packet of contraceptive pills to patients in an emergency. Perhaps, in this case, in view of her friend’s ‘blinding headaches’ this decision was not so wrong.

Family planning has been shown to be one of the most common areas in which nurses prescribe. Already, nurses are able to prescribe the complete range of contraceptives, and the expansion of nurse prescribing this year will allow qualified nurses to prescribe independently from the whole formulary, for any condition, as long as it is within their scope of competency. Surely this should be seen as a step forward for nurses, not in a purely negative and short sighted way as a cost-cutting measure.

I do applaud Ms Young’s beliefs that all specialist nurses need to have the ability to prescribe in their roles, and agree that this is an aspect of their role that could perhaps be addressed in the education of family planning nurses in the future. However, at present, this is not the case.

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Reference