LETTERS

Letters to the Editor

Full-term pregnancy with Implanon® in situ

An 18-year-old nulliparous woman who had had no bleeding since the insertion of an etonogestrel subdermal contraceptive implant (Implanon®) four months earlier had a positive pregnancy test. The implant was easily palpable and correctly sited. An ultrasound scan showed the gestation was 27.2 weeks.

Review of the patient’s general practitioner (GP) records indicated that the Implanon had been inadvertently inserted when she was already pregnant. She had not regained regular menstruation since stopping depot medroxyprogesterone acetate contraceptive (Depo-Provera) previously and switching to condoms. At the time of fitting she denied any sexual intercourse since splitting up with her boyfriend. She had had two negative pregnancy tests, one on the day of fitting.

Her GP (H.P.) referred her to a specialist contraception clinic for removal of the implant, where she attended 3 weeks after the pregnancy diagnosis (now 30 weeks’ gestation). The patient said she was always happy with the implant and would wish to use it again after delivery, and she asked if it had to be removed. The doctor in the clinic (H.C.) commented with the patient the lack of evidence about the correct course of action, and explained that progestogens in pregnancy have not been linked with fetal abnormality. In addition, it was unlikely that the rate of progesterone release from the implant would be altered in pregnancy and there was no reason to expect the low blood levels of progestogen to interfere with labour or delivery. Use of Implanon during lactation is standard (although the patient planned to bottle-feed). Keeping the implant in place therefore seemed to be an option.

The GP informed the manufacturers of Implanon (Organon), who of course recommended removal. Allegheny County University of Pittsburgh, 40,204
dated that: “Women may be reassured that although ovarian cysts occur in LNG-IUS users, there is no significant increased risk compared to IUD users”. The NICE guidelines published in October 20051 asserted that: “Development of ovarian follicular cysts ... occurs in 20% of women using the LNG-IUS”. But according to these NICE guidelines there is no need to inform patients about this risk prior to IUS insertion. “The LNG-IUS is a suitable option for most women who need contraception and/or treatment for menorrhagia” stated the FPFRHC Guidance.8 According to the NICE guidelines, the IUS is becoming one of the most cost effective, close to an ideal contraceptive method, with similar efficacy, ease of use and almost no absolute contraindications (except current malignancies or genitourinary tract infection) in women aged 18–50 years.9

Chlamydia rates in postcoital IUD recipients

Swab results were checked for 105 recipients of a postcoital intrauterine device (IUD) in Sheffield, UK in 2004. Only one chlamydia result was positive. A computer-generated list was used to identify all recipients of a postcoital IUD in Central Health Clinic, Sheffield in 2004. Paper notes were then obtained and checked. The age range of recipients was 13–52 years; 54 were aged under 25 years. All received pre-IUD counselling, including discussion regarding infection/sexually transmitted infections (STIs). All recipients were told that, as having had endocervical swabs for gonorrhoea and chlamydia. Results were checked both on computer and in the medical notes. One patient was excluded because of recent antibiotics (within 2 weeks of the swabs). One set of results could not be found. One result was positive for chlamydia and IUD recipients were advised to return for treatment.

One positive chlamydia result was less than the figure expected from local and national prevalence figures of 3–12%.12

Risk of infection can be discussed in the consultation to exclude those who are symptomatic for pelvic inflammatory disease or at high risk of acquiring an STI. We believe pre-IUD counselling helps clients most at risk of chlamydial infection to choose not to have an IUD fitted, even if the patient withholds relevant information (the informed user being a sensible person). A prospective study of all clients considering a postcoital IUD would be valuable to explore this impression further.

Our study supports research findings that prophylactic antibiotics are not cost-effective.3

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Mirena® IUS and ovulation function

“My accurate, up-to-date information is essential to enable users to make an informed and voluntary choice of contraceptive method”, declared the National Institute for Health and Clinical Excellence (NICE) guidelines,1 which also stated that “User satisfaction and successful use of contraception depend on adequate knowledge and accurate perceptions of the method”. At present there is strong evidence that the frequency of functional ovarian cysts is increased in the presence of the levonorgestrel-releasing intrauterine system (LNG-IUS). Some of the studies showed that as many as 30% of women identified ovarian cysts 3 months after LNG-IUS insertion.2 According to the NICE guidelines, “The incomplete suppression of ovarian activity in LNG-IUS users is a recipe not only for erratic bleeding, but also for the development of ovarian follicular cysts”.3 As stated in the Summary of Product Characteristics for the Mirena® IUS, functional ovarian cysts have been diagnosed in 10–12% of patients. In most cases they are small and asymptomatic, and disappear spontaneously.

The FPFRHC Guidance published in April

References

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References

Response
Thank you for the opportunity to respond to the letter from Dr Elena Valanche on ovarian cysts and the levonorgestrel-releasing intrauterine system (LNG-IUS) (Mirena®).

Based on the evidence, Faculty of Family Planning and Reproductive Health Care Guidance (April 2004) suggests that "women may be reassured that although ovarian cysts occur in levonorgestrel-releasing intrauterine system (LNG-IUS) users, there is no significant increased risk compared to copper-bearing intrauterine device users (Grade A)". A systematic review did not identify an increased risk of cysts in LNG-IUS users at 5 years compared to copper-bearing intrauterine device users (RR 1.5; 95% CI 0.51-4.4).1

The NICE guidance on 'Long-acting reversible contraception'3 states that ovarian follicular cysts occur in 20% of women using the LNG-IUS; however, these are almost always asymptomatic. In addition, spontaneous resolution of ovarian cysts in women using the LNG-IUS has been reported.4 Only one non-randomised study has reported that women discontinue with the LNG-IUS as a result of the development of ovarian cysts.5

The CEU suspends the counselling of women on potential risks and benefits of contraceptive methods.

"The CEU acknowledges that there is a lack of clear guidance on the management of functional ovarian cysts in women using the LNG-IUS. Moreover, there is little evidence on the management of all women of reproductive age with functional ovarian cysts and further research would be of benefit. The CEU is updating Guidance on the IUD and the LNG-IUS later this year. All new evidence will be identified and reviewed. However, at present there is no evidence to support the risk of ovarian cysts occurring. The CEU wishes to make clear that women with LNG-IUS should be reviewed and/or scanned to identify ovarian cysts. The CEU could find no evidence to support the statement that easier access to scanning facilities would improve the care of women presenting with pelvic pain in primary care. The etiology and pelvic pain in women of reproductive age may be due to many underlying causes, both physical and psychological, and allowing greater access to scan facilities may not be appropriate.

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References