the end of the stopper ring and since then I never
failed. Many colleagues have tried this method
and they have had success with it also.

I had correspondence from the French
company that unless the article were to be
endorsed by a professor or senior
consultant/colleague in family planning then they
were not prepared to change the design. The
Ortho Gynaec T 380® was discontinued, however
it has been adopted for use by other
manufacturers with only minor changes, and I am
afraid the inherent problem is still present. One
has tried to make loading easier but still the
problem doesn’t disappear completely.

My proposal was very simple: no matter how
you load the introducer rod in the tube it should
come out outside the top opening and then one
can be absolutely sure that the IUD is released
totally and completely and that there is no chance
of the IUD being pulled down.

For those colleagues who would like to try
my technique they should do the following. Put
the IUD on sterile paper. Pull the IUD out further
up so that one does not cut the thread. Line the
rod against the tube with the rod just a few
millimetres (say 4–5 mm) higher than the
opening and then the lower end of the tube should
be cut. The rod should rest at the end of the rod
where there is a ring. Subsequent fitting should
now be easier.

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Increase in IUD expulsions
I write as the UK distributor for the TT 380
Slimline® intrauterine device (IUD), following
the publication of the letter from Drs Hawkins
and Callandar in the October 2006 issue of the
Journal concerning IUD expulsions.

Neither Durbin PLC, nor the French
manufacturer (7-MED Industrie), can explain
what has happened, although the clinical skills of
the two doctors are beyond reproach. Since 2002
approximately 205 000 TT 380 Slimline devices
have been fitted in France alone, with only three
reported expulsions. I and I am

There is a European Standard for the
‘resilience’ of the horizontal arms which the TT
380 Slimline meets, and the manufacturer does
not accept that the arms regained their
shape after compression is connected to the
reported expulsions.

I would refer the Journal’s readers to the
poster presentation by Dr Paul O’Brien
(Westminster PCT, London, UK) at the 8th
Congress of the European Society of
Contraception held in Edinburgh, UK in June 2004.
(NB. Copies of the poster are available from me on
request.) This poster reviewed published studies on the T380 ‘A’ version (where the copper
sleeves on the horizontal arms stand proud of the
plastic) and the T380 ‘Slimline’ version (where the
copper on the horizontal arms is flush with the
plastic and closer to the ends), which may cast some light on the
topics.

Dr O’Brien’s review revealed an increase in
expulsions in the first year with the ‘Slimline’
version compared to the ‘A’ version. By Years 4
and 5 the expulsion rates with both types were similar.

The T-Safe 380 A changed to the ‘Slimline’
format in June 2005. The results of Dr Hawkins
and Callandar refer to T-Safe usage up to Autumn
2005. Allowing for the stock holding in the
distribution chain, it is probable that most of the
T-Safe devices fitted in the period referred to were
of the original ‘A’ style. (NB. It is interesting to note that although all the T-Safe

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EURAS Study results
Final results of the European Active
Surveillance (EURAS) Study were presented at the
XVII FIGO World Congress of Obstetrics
and Gynaecology in Kuala Lumpur, Malaysia on
9 November 2006. This post-marketing
surveillance study took place between
2000 and 2006, with 58 674 participants
followed up for 142 475 woman-years. The aim
of the study was to monitor cardiovascular
outcomes in combined oral contraceptive
(COC) users, specifically comparing those on Yasmin®
with other COC users. The scale of the study,
amount of detailed information collected about
each woman (with regard to relevant
cardiovascular risk factors) and the fact that
only 2.3% of women were lost to follow-up
make this a unique and useful investigation.

As has been noted in previous studies of
cardiovascular risks, women using the newest
preparation (in this case Yasmin) were at
slightly higher risk at entry (e.g. were more
likely to be obese). Interim results of this study had
already shown higher than expected absolute
risks of venous thromboembolism (VTE) in all groups, and the final results showed
no significant difference in arterial
risk factors, compared to non-
users. The study results are to be published in the
journal, Contraception, early in 2007.

Reported by Anne Szarewski, PhD, FFPFP
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Risk of VTE with oral contraceptives
A free communication presented at the XVIII
FIGO World Congress of Obstetrics and
Gynaecology in Kuala Lumpur, Malaysia investigated whether gestodene-containing oral
contraceptive (OC) pills carried a higher risk of
venous thromboembolism (VTE) compared to
levonorgestrel-containing OCs. A population-
based case-control study was undertaken in 2005
amongst Austrian women aged between 15
and 49 years. Interim results were presented
involving 408 cases and 1339 controls. The odds
ratio for developing a VTE with an OC versus
non-use was 2.8 (95% CI 1.1–3.6) for all OCs,
2.7 (95% CI 1.9–3.8) for gestodene-containing
OCs and 2.9 (95% CI 1.5–5.8) for
levonorgestrel-containing OCs. A head-to-head
comparison comparing gestodene-containing
OCs versus levonorgestrel-containing OCs
showed an odds ratio of 1.2 (95% CI 0.6–2.7).

This study confirmed an increased risk of
VTE associated with the use of any combined
OC pill, with a similar odds ratio to that found in
previous studies. However, in 2005 there was no
significant difference in VTE risk in this
population of women taking a gestodene-
containing pill compared to a levonorgestrel-
containing pill. It is important to note that this
study was designed to reduce potential
confounders and biases by using controls with
the same year of birth from this same region of
Austria as the identified cases. The cases
included those who had VTEs diagnosed and
treated in an outpatient setting as well as
inpatients.

The authors conclude that their
contemporary study results differ from those
found in the 1990s because user populations of
second- and third-generation OC pills have
changed.

Reference
1 Heinemann L, Dinger J, Assmann A. The risk of
venous thromboembolism (VTE) in oral
contraceptives: a new lesson. Presentation at the
XVII FIGO World Congress of Obstetrics and
Gynaecology, Kuala Lumpur, Malaysia, 5–10
November 2006.

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