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 Gynae 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, which should rest at the end of the rod where there is a ring. Subsequent fitting should now be easier.

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References
1 Hawkins F, Callander F. Increase in IUD expulsions (Letter). *J Fam Plann Reprod Health Care* 2006; **32**: 267.
2 Yadava RP. Self removal of Mirena IUS (Letter). *Br J Fam Plann* 1997; **22**: 59.

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 Callander in the October 2006 issue of the Journal concerning IUD expulsions.[1]

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.

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 way the arms regain 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 arms is flush with the plastic and closer to the ends), which may cast some light on the topic.

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 devices now available are of the 'Slimline' type, the product is still described as '380 A' on its packaging!)

Notwithstanding all of the above remarks, the manufacturer of the TT 380 Slimline device, in view of the volume now used in the UK, have proposed some design changes purely for the UK market. These changes, which will be on stock produced from January 2007, will result in an increase in the resistance to expulsion.

Any readers requiring further information, evaluation samples, and so on, are invited to contact me directly.

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Reference
1 Hawkins F, Callander F. Increase in IUD expulsions (Letter). *J Fam Plann Reprod Health Care* 2006; **32**: 267.

Ancient condoms

Further to the article in the October 2006 issue of the Journal on the history of condoms,[1] readers may be interested to know that amongst the finds in Tutankhamen's tomb was a linen condom with long strings to attach. The condom is now on show in the Cairo Museum alongside the more famous artefacts, which goes to show that one can't be too careful – even in the afterlife!

Lesley Smith
Curator, Tutbury Castle, Tutbury, Staffordshire, UK. E-mail: info@tutburycastle.com

Reference
1 Edouard L. In condoms we trust: to each, one's own. *J Fam Plann Reprod Health Care* 2006; **32**: 262–264.

NEWS ROUNDUP

EURAS Study results

Final results of the European Active Surveillance (EURAS) Study were presented at the XVIII FIGO World Congress of Obstetrics and Gynaecology in Kuala Lumpur, Malaysia on 9 November 2006. This post-marketing surveillance cohort 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 2.39% 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 a risk for non-pregnant, non-COC users of 44 per 100 000 woman-years. All COC users, regardless of preparation, had a similar, elevated risk of VTE, at approximately 90 per 100 000 woman-years. The risk was increased to 230 per 100 000 in women with a body mass index (BMI) over 30, which was a five-fold increase compared to women whose BMI was 20–24 and a three-fold increase compared to those whose BMI was 25–29. Increasing age was also a significant risk factor.

No increase was seen in risks of arterial disease for any preparation, compared to non-users. The study results are to be published in the journal, *Contraception*, early in 2007.

Reported by **Anne Szarewski**, PhD, FFFP
Editor-in-Chief, Journal of Family Planning and Reproductive Health Care

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 2.1–3.6) 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 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 XVIII FIGO World Congress of Obstetrics and Gynaecology, Kuala Lumpur, Malaysia, 5–10 November 2006.

Reported by **Diana Mansour**, FRCOG, FFFP
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Missed pills and different oral contraceptive regimens

At the recent XVIII FIGO World Congress of Obstetrics and Gynaecology in Kuala Lumpur, Malaysia evidence was presented showing a decrease in ovarian activity in women taking a 20 μg ethinylestradiol/3 mg drospirenone oral contraceptive pill with a 4- rather than a 7-day hormone-free interval. Fifty-two healthy women who had ovulated or shown a follicle-like structure ≥15 mm during the pretreatment cycle were admitted into this double-blind randomised study. Suppression of ovarian activity, using the Hoogland score, was more pronounced with the 20 μg ethinylestradiol/3 mg drospirenone 24/4 regime compared to the 21/7 regime.

Furthermore, 104 women aged 18–35 years were randomly allocated to taking these two pill regimes and asked to miss the first three active pills of cycle three. Hence for this cycle one group would have the equivalent of a 7-day hormone-free interval, and the second a 10-day interval. For cycles one and two no one ovulated in the 24/4 group but there was one ovulation in cycle two for the 21/7 pill regime. In cycle three, when the first three active pills had been missed at the beginning of the cycle, one ovulation occurred in the 24/4 regime and four ovulations in women taking the 21/7 regime. These data, yet again, emphasised the importance of correct and consistent pill taking and questions the safety of recently published 'missed pill guidance'.

Reference

1 Schulman LP. Discover YAZ: the only drospirenone containing oral contraceptive with proven premenstrual dysphoric disorder benefits. Presentation at the XVIII FIGO World Congress of Obstetrics and Gynaecology, Kuala Lumpur, Malaysia, 5–10 November 2006

Reported by **Diana Mansour**, FRCOG, FFFP
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An irritating problem

Sexually active or not, many women and girls suffer from discomfort and discharge. Embarrassment may delay or prevent individuals seeking medical help, but most cases can be resolved with simple tests and appropriate therapy. One thing that this handy review manages to omit entirely is the simple yet effective measures of avoiding harsh detergents and synthetic underwear.

Source: http://content.nejm.org/cgi/content/ extract/355/12/1244

Reported by **Gill Wakley**, MD, FFFP
Writer, ex-GP and retired Professor in Primary Care Development, Abergavenny, UK

STIs in primary care

The Royal College of General Practitioners (RCGP) Sex, Drugs and HIV Task Group and the British Association for Sexual Health and HIV (BASHH) have jointly published an 80-page document entitled *Sexually Transmitted Infections in Primary Care*. This document has been written in response to the growing number of STIs that are being diagnosed in primary care in the UK, and the increasing engagement of GPs in managing sexual health, as encouraged by the National Strategy for Sexual Health and HIV. This document can be downloaded free of charge and will serve as a useful reference source for GPs, practice nurses and health care professionals working in allied fields.

Source: http://www.rcgp.org.uk/PDF/clinspec_STI_in_ primary_ care_NLazaro.pdf

Reported by **Gill Wakley**, MD, FFFP
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Support on sexual health for boys and young men

The number of boys and young men contacting Brook, the sexual health charity for young people, for advice on sexual health issues such as contraception and STIs has more than tripled in the last 10 years. However, too many boys and young men still feel there is a stigma attached to asking for help, and sexual health services across the country tend to be biased towards the needs of women, said Simon Blake, Chief Executive of Brook. Almost 20 000 boys and young men under the age of 25 years visited one of Brook's 17 centres for confidential sexual health services and advice in 2005–2006, accounting for 19% of the total number of Brook clients. This represents an increase of 14% on the previous year's figures, continuing the upward trend in the number of male Brook clients under 25, which has increased by 215% over the last 10 years. Since the start of the Teenage Pregnancy Strategy, the proportion of boys and young men using contraceptive clinics and GPs has increased from 9% to 29%, but the proportion remains considerably lower than for girls.[1]

For further information contact Brook. Tel: 0800 0185 023. www.brook.org.uk.

Reference

1 *Teenage Pregnancy Strategy Evaluation Report*. 2005. http://www.dfes.gov.uk/teenagepregnancy/dsp_showDoc.cfm?FileName=ACF3396%2Epdf [Accessed 18 November 2006].

Reported by **Henrietta Hughes,** MRCGP, DFFP
GP, London, UK

Government's sexual health campaign

The Government has launched a hard-hitting safe-sex campaign in response to rising sexually transmitted infection (STI) rates. The campaign message is that you cannot tell who has an infection by looking at them, and features semi-naked models wearing pants with slogans such as "I've got gonorrhoea". Advertisements also feature men and women in T-shirts emblazoned with the words "I'll Give You One" above a headline explaining that "it's not this easy to tell" if someone is infected.

Source: Reuters, 11 November 2006

Reported by **Henrietta Hughes**, MRCGP, DFFP
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First HIV and AIDS resource for the English curriculum

AWARE! The Crusaid Media Kit will be sent to 1500 schools across London during 2007. The kit features the UK's original AIDS awareness TV advertisement from the 1980s and encourages students to devise their own AIDS awareness campaign aimed at teenagers. It is the first time a teaching module on HIV has been created for the mainstream English curriculum.

For further information visit http://www.awareuk.info/ and www.crusaid.org.uk.

Reported by **Henrietta Hughes**, MRCGP, DFFP
GP, London, UK

Lancet series on sexual and reproductive health

The Lancet has published a series on sexual and reproductive health online. The series highlights the global burden of ill health in a variety of key areas including STIs, contraception, unintended pregnancies and unsafe abortions. In addition to the series articles (detailed below) the collection includes comments and original research.

Source: http://www.thelancet.com/collections/ series/srh

Reported by **Henrietta Hughes**, MRCGP, DFFP
GP, London, UK

The Twelve STIs of Christmas

An animated reminder of the wide range of STIs, this website also has links to www.playingsafely.com, which has more information about signs and symptoms of STIs.

Source: http://mclewin.com/files/uploaded/12-STIs.swf

Reported by **Henrietta Hughes**, MRCGP, DFFP
GP, London, UK

Assessment toolkit for managing STIs within primary care

A best practice toolkit has been developed to assess the range of competencies in skills, knowledge and attitudes required to deliver more specialised sexual health services within primary care. The toolkit has been developed by the Department of Health, British Association for Sexual Health and HIV (BASHH), Royal College of General Practitioners' Sex, Drugs and HIV Task Group, Faculty of Family Planning and Reproductive Health Care, Royal College of Obstetricians and Gynaecologists, Royal College of Nursing, and the National Association of Nurses for Contraception and Sexual Health. The toolkit is transferable to any primary care setting and supports improving quality in managing STIs.

For more information contact Teresa Battison/Kate Henderson-Nichol, National Programme Delivery. Tel: +44 (0)20 7972 1527.

Reported by **Henrietta Hughes**, MRCGP, DFFP
GP, London, UK

VOLUNTEERS NEEDED TO REVIEW BOOKS FOR THE JOURNAL

The Journal regularly receives books for review and for this it relies on the services of a small team of expert reviewers. Whilst no payment is offered in respect of this role, reviewers do get to keep the books they review thus offering an opportunity to build up reviewer's own or their departmental book collection.

For further information please contact the Journal's Book Review Editor, Dr Kate Weaver via e-mail (**kate.weaver@lpct.scot.nhs.uk**). Please provide your contact details (mail and e-mail addresses), together with a note of any special interests and/or expertise.