Cytology sampling using brushes
I write in response to the letter from Dr Leng Neoh in the April 2007 issue of the Journal.1 As an experienced cervical sample taker I agree with Dr Neoh that when sampling the cervix using the Cervex-Brush® cause is required if the client has an intrauterine device or intrauterine system (IUD/IUS) in situ to ensure the physician does not inadvertently remove the IUD during sampling.

However, I must point out that the plastic fronds of the brushes are bevelled for clockwise rotation only.2 The Cervex-Brush should be rotated five times in a clockwise direction and not, as stated by Dr Neoh, “five times clockwise and five times anti-clockwise”. This is incorrect sampling and there is also more risk of the threads getting caught on the fronds. When presented with the above situation, my practice is to rotate the Cervex-Brush five times in a clockwise direction, but to do it in two stages, namely after rotating twice, stop, remove the brush from the cervix (but not from the vagina) and from any threads that may be starting to become entangled, and then continue sampling to complete the five rotations, ensuring the brush is repositioned at the same point on the cervix where the second rotation finished. I have found that although the threads may start to become entangled, it is less likely that they will become caught with the brush from them without dislodging the IUD.

Using a Spencer Wells forceps as suggested by Dr Neoh is also an option but this requires some skill and dislodging the IUD/USY by the actions of the forceps.

References

Increase in IUD expulsions
It was with great interest, and a sense of déjà-vu, that I read the recent correspondence concerning insertion problems with the IUD/IUS.1

Reading Dr Yadava’s original letter in 19962 enabled me to identify the cause of the problems that I had been experiencing with insertion, and follow up my results: I had modified the technique (cutting the introducer tube shorter) I experienced no further problems.

It was unfortunate that the manufacturer (in this case at least) did not react positively to this modification and the device, and that the apparent design problem has been passed on to newer devices.

In the light of this new evidence, I would like to reiterate my suggestion that it might be appropriate for the Faculty to take up the matter with the manufacturer.

Robert J T Jarvis, MFFP
General Practitioner, The Surgery, Ludham, Norfolk, UK. E-mail: rj.jarvis@binternet.com

References

Impact of safe abortion on maternal mortality: a reassessment
It is well known that the maternal mortality rates in India are among the highest in the world. A recent study by the World Health Organization (WHO) estimated that 58% of all maternal deaths in 2000 were due to unsafe abortion.1

Unsafe abortion, a major public health problem, is prevented and limited by the availability of contraceptive services. However, the priority given to these services varies from country to country. In some countries, contraceptive services are widely available, while in others they are not. This variation in the availability of contraceptive services is partly due to the lack of political will to provide these services.

In conclusion, the concern of unsafe abortion and maternal mortality will be drastically reduced if not completely eliminated if specific and goal-directed actions are taken. Such actions include promoting women’s rights, status and health; ensuring access to contraception; providing post-abortion services, including counselling; putting referral systems in place; and de-criminalising abortion and changing laws where they are restrictive. All relevant agencies are called upon to initiate authentic programmes that will curb this carnage from unsafe abortion as part of the overall strategy for achieving the millennium development goal, not only in Nigeria but also in most developing countries of the world.

References