unsafe abortion, improved and expanded family planning services must be given the highest priority. Twelve years after the Cairo conference, the contraceptive prevalence in Nigeria is 7.3%. This is worse for adolescent girls and unmarried women who are frequently excluded from contraceptive services. In many developing countries, lack of information on sexuality and contraceptive services, the adolescent population has often translated into a high prevalence of unwanted pregnancy. Thus, there is great need for the establishment of accessible and affordable contraceptive services, different from a hospital setting, where these vulnerable groups can go for care. Such centres should be equipped to offer services on family planning counselling and information, education on reproductive physiology and overall safer sex, and should be able to provide post-abortion care services. Also, regulations, policies, and laws that restrict adolescents’ access to such services should be revised.

In conclusion, the contribution of unsafe abortion to 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 family planning services, including counselling; putting referral systems in place; and decriminalising 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 both 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.

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Cerazette and HRT
A general practitioner (GP) wrote into our recent article recently to ask if Cerazette® could be used as the progestogen part of hormone replacement therapy (HRT). I would be interested in the views of other Faculty members about this.

The progestogen-only pill (POP) has been used traditionally as part of HRT regimes, although is not licensed for this indication. It has always been postulated that from the perspective of contraception, as the additional oestrogen in the HRT, might ‘undo’ the mucous thickening effect of the POP, that when used as part of HRT the chance of POP failure should be doubled (or trebled). As the newer POP, Cerazette works by inhibiting ovulation in almost all cases, this should not be the case with Cerazette as part of an HRT regimen.

In addition, I believe there has been studies of desogestrel as part of the HRT regime, but these were halted as a result of the 1995 pill scare and the venous thromboembolism issue with third-generation progestogens. A 1996 study by Saure et al was a randomised double-blind multicentre study of 310 women, comparing the effects of two sequential HRT preparations, containing either norethisterone or desogestrel. Both regimes successfully alleviated menopausal symptoms, and there was no significant difference in bleeding patterns with the two combinations. There was no endometrial hyperplasia or atypia identified during the study.

My own view is that using Cerazette as the progestogen part of HRT would be acceptable practice. However, women of perimenopausal age do have much reduced fertility, and some would say that Cerazette, whilst it offers an additional choice of POP, could be regarded as ‘contraceptive overkill’. We cannot, however, get away from the fact that the 12-hour rule for daily administration with Cerazette makes it considerably easier to take.

The question remains as to whether Implanon® could be used as part of an HRT regime, I feel it is unlikely this would be the case, but would be interested in readers’ views on this subject.

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Cytology sampling using brushes
I read with interest the letter from Dr Leng Neoh in the April 2007 issue of the Journal.

I would like to question the technique of collecting a cervical cytology sample using the new liquid-based cytology (LBC) Cervex-Brush® described by the author. The National Health Service Cervical Screening Programme (NHSCSP) guidance on taking samples for LBC (LBC http://www.cancerscreening.nhs.uk/cervical/lbc04.pdf [Accessed 27 April 2007]) recommends that the cervix is brushed five times at the external cervical os ‘clockwise only’. Perhaps the technique described by the author that involves rotating the brush at the cervical os five times clockwise and anticlockwise may have inadvertently caused downward traction on the threads of the intrauterine device leading to its ‘unintentional removal’. I do not see any benefit in using a Spencer Wells forceps as suggested by the author to minimise this risk. In fact, I wonder how one could rotate the Cervix brush with the Spencer Wells forceps near the external cervical os and that this technique may be a potential cause for inadequate sampling of the cervix.

I would appreciate readers’ comments.

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References

Cytology sampling using brushes
I write in response to the letter from Dr Leng Neoh in the April 2007 issue of the Journal.

As an experienced cervical sample taker I agree with Dr Neoh that when sampling the cervix using the Cervex-Brush® cause is required when the client has an intrauterine device or intrauterine system (IUD/IUS) in situ to ensure the medician 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. 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 thread being pulled through the device.

When presented with the above situation, my practice is to rotate the Cervix-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 be 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 very rare that when the brushing 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 may dislodge the IUD/IUS by the traction on the threads. This also necessitates having a ready supply of instruments.

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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.

Reading Dr Yadava’s original letter in 1996′ enabled me to identify the cause of the problems that I had been experience with insertion, and following my discussion with Dr Neoh (cutting the introducer tube shorter) I experienced no further problems.

It was unfortunate that the manufacturer (in this instance at least?) supplied a tool to modify 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.

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