

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%.⁵ This is worse for adolescents and unmarried women who are frequently excluded from contraceptive services. In many developing countries, lack of information on sexuality and contraception targeted at 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 youth-friendly centres, 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/or 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 post-abortion care services, including counselling; putting referral systems in place; 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 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.

Perpetus Chudi Ibekwe, MBBS, FWACS

Department of Obstetrics and Gynaecology,
Ebonyi State University Teaching Hospital,
Abakaliki, Nigeria.
E-mail: drogopers@yahoo.com

References

- 1 World Health Organization (WHO). *Safe Abortion: Technical and Policy Guidance for Health Systems*. Geneva, Switzerland: WHO, 2003.
- 2 World Health Organization (WHO). *Unsafe Abortion: Global and Regional Estimates of Incidence of Unsafe Abortion and Associated Mortality in 2000* (4th edn). Geneva, Switzerland: WHO, 2004.
- 3 Henshaw SK, Singh S, Oye-Adeniran BA, Adewole IF, Iwera N, Cuca YP. The incidence of induced abortion in Nigeria. *Int Fam Plann Perspect* 1999; **24**: 156–164.
- 4 Adefuye PO, Sule-odu AO, Olatunji AO, Lamina MA, Oladapo OT. Maternal deaths from induced abortions. *Trop J Obstet Gynaecol* 2003; **20**: 101–104.
- 5 Oye-Adeniran BA, Adewole IF, Odeyemi KA, Ekanem EE, Umoh AV. Contraceptive prevalence among young women in Nigeria. *J Obstet Gynaecol* 2005; **25**: 182–185.

Cerazette and HRT

A general practitioner (GP) wrote into our service 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 mucus thickening effect of the POP, that when used as part of HRT the dose of POP 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 regime.

In addition, I believe there have 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.*² was a randomised double-blind multicentre study of 310 women, comparing the effects of two sequential HRT preparations, containing either estradiol and norethisterone, or estradiol and 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 should 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.

Deborah J Lee, MFFP, MRCGP

Associate Specialist in Reproductive Health,
Lead for Medical Education and Training,
Lead for Unplanned Pregnancy, Southampton
Contraception & Sexual Health Service,
The Quay to Health, Southampton, UK.
E-mail: debbie.lee@scept.nhs.uk

References

- 1 Cerazette Summary of Product Characteristics. <http://emc.medicines.org.uk> [Accessed 27 April 2007].
- 2 Saure A, Hirvonen E, Milsom I, Christensen A, Damber MG. A randomised, double blind, multicentre study comparing the clinical effects of two sequential estradiol-progestin combinations containing either desogestrel or norethisterone acetate in climacteric women with estrogen deficiency symptoms. *Maturitas* 1996; **24**(1–2): 111–118.

Cytology sampling using brushes

I read with interest the letter from Dr Leng Neoh in the April 2007 issue of the Journal.¹

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) guidance² on taking samples for LBC recommends that the Cervex brush is rotated 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 anti-clockwise 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 Cervex 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.

Anagha A Nadgir, MRCOG, MFFP

Associate Specialist, Contraception and Sexual
Health Service, Middlesbrough PCT, North
Ormesby, Middlesbrough, UK.
E-mail: anagha.nadgir@nhs.net

References

- 1 Neoh L. Cytology sampling using brushes [Letter]. *J Fam Plann Reprod Health Care* 2007; **33**: 135.
- 2 NHS Cancer Screening Programmes. *Training in Taking Samples for Liquid Based Cytology (LBC) Implementation Guide No. 4* Version 1, May 2004. <http://www.cancerscreening.nhs.uk/cervical/lbc04.pdf> [Accessed 27 April 2007].

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® caution is required when the client has an intrauterine device or intrauterine system (IUD/IUS) *in situ* to ensure the clinician does not inadvertently remove the IUD during sampling.

However, I must point out that the plastic fronds of the brush 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 becoming tangled.

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 easy to remove 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 may dislodge the IUD/IUS by the traction on the threads. This also necessitates having a ready supply of instruments.

Suzanne Jones, RGN

Lead Nurse, Abacus Clinics, Liverpool, UK.
E-mail: suzanne.jones@liverpoolpct.nhs

References

- 1 Neoh L. Cytology sampling using brushes [Letter]. *J Fam Plann Reprod Health Care* 2007; **33**: 135.
- 2 National Health Service Cancer Screening Programme (NHSCSP). *Taking Samples for Cervical Screening, A Resource Pack for Trainers*. NHSCSP Publication No 23. Department of Health (April 2006).

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 TT380 Slimline.^{1–3}

Reading Dr Yadava's original letter in 1996⁴ enabled me to identify the cause of the problems that I had been experiencing with insertion, and following my adoption of his modification (cutting the introducer tube shorter) I experienced no further problems.

It was unfortunate that the manufacturer (in this country at least^{2,3,5}) was unwilling 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 suggestion⁶ 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: rjt.jarvis@btinternet.com

References

- 1 Hawkins F, Callander F. Increase in IUD expulsions [Letter]. *J Fam Plann Reprod Health Care* 2006; **32**: 267.
- 2 Yadava RP. Increase in IUD expulsions [Letter]. *J Fam Plann Reprod Health Care* 2007; **33**: 65–66.
- 3 Yadava RP. Increase in IUD expulsions [Letter]. *J Fam Plann Reprod Health Care* 2007; **33**: 133.
- 4 Yadava RP. Ortho Gynae T380S Slimline fitting made easier? [Letter]. *Br J Fam Plann* 1995; **21**: 78.
- 5 Homouda K. The effect of intrauterine device position and performance of a modified TCu380A insertion technique. *Eur J Contracept Reprod Health Care* 2002; **7**: 31–35.
- 6 Jarvis RJT. Ortho Gynae T Slimline fitting [Letter]. *Br J Fam Plann* 1996; **22**: 107.