a major problem when my generation of GPs retires and IUD fitters will not be replaced. Surely the role of the Faculty should be to increase and encourage training, rather than to stick to rigid and outdated requirements?

The present LoC IUT allows a doctor to fit any device once they have completed seven insertions. This means that they could fit six Mirenas and one Flexi-T® and then be deemed competent to fit a Nova T380® or a TT380 Slimline®. It does not, quite reasonably, demand that they fit all available devices. It requires doctors to practise within their field of competence and to refer on any procedure at which they do not feel competent. The Faculty CD-ROM on intrauterine techniques is extremely useful and I am sure that most doctors would refer to that before fitting a device with which they were not too familiar. Most of us trained ourselves by simply reading the instructions on the pack! I cannot see why there should still be a requirement for two different devices to be fitted. If the rules are not amended, there is going to be a severe lack of doctors being trained to fit IUDs. This only serves to diminish even more the patient's right to choose.

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Menstrual migraine

I read with interest Dr Anne MacGregor's review on menstrual migraine in the January 2007 issue of the Journal.[1]

On page 44, under the title 'Perimenstrual oestrogen supplements', Dr MacGregor explained when such supplements are not recommended. The use of perimenstrual oestrogen such as transdermal oestrogen (100 µg daily) in the prophylaxis of menstrual migraine is of concern because of the apparent synergism between migraine and contraceptive oestrogen as risk factors for stroke.[2] I think other forms of oestrogen that are not a component of a contraceptive method are not free of such risks. The Members' Enquiry Response[2] and myself were surprised by the guidance of BASH[3] and PRODIGY[4] on the use of transdermal oestrogen for prevention of menstrual migraine. I will not recommend it in the prevention of menstrual migraine, especially if it is associated with further risk factors such as the presence of aura. The absolute risk of ischaemic stroke in those women is fortunately very small but prevention is the preferred option.

In one patient with menstrual migraine, I used a non-steroidal anti-inflammatory drug, as a prophylactic treatment, that delayed the migraine to other times of the cycle. The patient is currently well controlled on gabapentin.

On page 44, under the title 'Continuous combined hormonal contraceptives', other conditions related to migraine were not stated, when such therapy should not be used. Combined oral contraception is absolutely contraindicated in women with migraine without aura if they have more than one additional risk factors for stroke such as age over 35 years, smoker or obesity.

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Reply

I am grateful to Dr Al-Hassan for giving me the opportunity to clarify the safety of oestrogen supplements for the prevention of menstrual migraine.

As mentioned in the review, compared to non-menstrual attacks, menstrual migraines are more severe, last longer, are less responsive to symptomatic treatment and more likely to relapse.[1] Prophylaxis for menstrual migraine is indicated when acute therapy does not adequately control symptoms. The rationale for short-term perimenstrual prophylaxis is to target intervention to the time of need, limiting potential side effects of medication to a few days rather than throughout the cycle. As Dr Al-Hassan emphasises, it is important that such treatments are safe.

Regarding the concern about migraine aura, menstrual migraine is, by definition, without aura so the issue of using oestrogen supplements for migraine with aura should not apply.[2] I address the risk of oestrogen replacement in women with migraine with aura in a review in this issue of the journal.[3]

Also important is the different pathophysiology of migraine with aura compared to migraine without aura, with respect to oestrogen. Although high doses of oestrogen are often associated with the development of aura, withdrawal of oestrogen precipitates migraine without aura.[4] This is the rationale for using oestrogen supplements to bridge the interval between the luteal phase oestrogen decline and the follicular phase rise. The recommended dose of oestrogen, 100 µg patches provide plasma levels of oestrogen of the order of 382 ± 232 pmol/l (i.e. maintaining luteal phase levels).[5] On this basis, the risk of ischaemic stroke associated with perimenstrual supplements should be no greater than the risk associated with the normal menstrual cycle.

In contrast to physiological doses of natural oestrogens, combined hormonal contraceptives (CHCs) contain potent synthetic oestrogens in order to suppress ovulation. Even when taken by healthy women, CHCs are associated with a small but measurable increased risk of ischaemic stroke. This risk has not been shown for natural oestrogens used by perimenopausal women.[6] It is unclear why, in their evidence-based response, the Clinical Effectiveness Unit have extrapolated data regarding increased risk of ischaemic stroke in women with migraine associated with use of CHCs to imply that the same risk is associated with use of physiological doses of natural oestrogens.[7] In addition, since there is evidence that risk of stroke is associated with frequency of migraine, one could speculate that preventing attacks might be associated with reduced risk.[8]

On that note, Dr Al-Hassan remarks on delayed migraine following perimenstrual prophylaxis with non-steroidal anti-inflammatory drugs. This has also been shown with perimenstrual prophylaxis with oestrogen and with naratriptan.[9,10] From a clinical perspective, although this can be a problem for individual women, it is not a problem for all. It is usually resolved by extending the duration of perimenstrual prophylaxis and tapering the dose or, as Dr Al-Hassan correctly notes, by continuous prophylaxis.

Finally, prohibiting use of CHCs in women with migraine without aura who have more than one additional risk factor for stroke has been the standard recommendation for a number of years and was based on the evidence available at the time.[11] In light of new research, there is increasing evidence to suggest that the risk of ischaemic stroke associated with migraine without aura is not significant.[12] Hence, my recommendation is that there is no reason to restrict use of CHCs by healthy, non-smoking women over the age of 35 years who have migraine without aura.

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Review of abortion laws

Ann Furedi's[1] is the most recent voice to call for a review of the 1967 Abortion Act,[2] seeking to set aside some of the checks and balances, which she believes are restrictive. Others, however, feel the laws are too liberal and should be tightened.[3] Whatever might have been the driving force behind the Act, it was well crafted with the interest of the woman uppermost and remains as relevant today despite its age of 40 years. It has sufficient checks and balances in place to allow women access to terminate unwanted pregnancies, by trained people who want to provide the service in regulated premises to ensure safety and avoid morbidity. The Act does not need amending either one way or the other. Advances in medicine are occurring all the time and some of these have been incorporated into providing abortions without a need to amend the Abortion Act (e.g. nurse-led medical abortions).

There is concern, however, that numbers of terminated pregnancies continue to rise[4] and therein lies the problem, the solution of which is not to amend the abortion laws. Most women wanting to terminate pregnancies became pregnant as a result of non-use or poor use of contraception.[5] More effort needs to be put into preventing unwanted pregnancies in the first place by effective and reliable contraception. If there were no unwanted pregnancies there would be no requests for termination of pregnancies. The National Institute for Health and Clinical Excellence (NICE) has recommended long-acting reversible contraceptives (LARC) as the contraceptives of choice,[6] yet these remain poorly promoted and not readily available to women as many general practice surgeries do not provide the full range of these methods.[7]

Furedi[1] attempts to draw parallels between the rights of competent pregnant women to refuse