
This is another of the large meta-analyses regularly produced by this group of researchers. This time they have looked at ovarian cancer risk and the combined oral contraceptive pill (COC), and confirmed that the COC greatly reduces the risk. The risk decreased by 20% with every 5 years of COC use, and for women who took the pill for 15 years, the risk was halved. The duration of protection lasted for many years after stopping the pill, even after 30 years there was still a significant reduction in risk [relative risk (RR) 0.86, 95% CI 0.76–0.97]. Between 10 and 19 years after stopping, the RR was 0.67 (95% CI 0.62–0.73), namely a roughly 40% reduction in risk. Importantly, the authors conclude that the protective effect is similar for both high- and low-estrogen COCs. They estimate that around 200 000 ovarian cancers have already been prevented by COC use in the last 50 years and predict that around 30 000 cases of ovarian cancer per year will be prevented in future. Two accompanying editorials both suggest that the pill should be made available over the counter, though without any suggestions of how this should be done in practice to maintain patient safety.

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LETTERS TO THE EDITOR

Difficult insertion of IUS

We were relieved to read the letter1 about difficult insertion of the intrauterine system (IUS) in the October 2007 issue of the Journal because we and at least one other colleague have had exactly the same experience.

1 (MD) have been fitting intrauterine devices (IUDs) for over 35 years and have had six or seven of these in the last year, each needing another IUS or indeed another IUD usually the TT380 Slimline®. I fit on average 10 IUDs per day.

A colleague, who is also a general practitioner, with more than 5 years’ experience, fits on average 20 per year. She has come across this problem twice, one episode requiring opening a third IUS to get it fitted, thus believing something wrong with the technique so that there be devices not correctly placed at the fundus.

The fitting of the TT380 Slimline differs entirely as the plunger is held at the base of the IUD before removing the insertion tube so we have never had a problem with it.

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References

Difficult IUD insertions

I write in response to the issue raised by Dr Isabel Draper.1 I share her sentiments that insertion of intrauterine contraception has become progressively more challenging as we see increasing numbers of nulliparous women requesting a copper intrauterine device (IUD) or Mirena® for contraception plus many older women requesting a Mirena® for gynaecological indications and combined hormone replacement therapy. In the community clinic setting, we may have eight or nine such women for intrauterine contraception in a session plus have to balance this with the needs of a training doctor. Insertion of intrauterine contraception is often deeply unpleasant for nulliparous and older women, particularly if the procedure is being undertaken by an inexpert doctor. A carefully and gently applied intracervical injection of local anaesthetic makes a huge difference to the tolerability of difficult and painful insertions.

Local anaesthetic allows for easier insertion of the banded copper IUD or Mirena. In addition, local anaesthetic blocks the vasovagal response which can have an impact on the smooth running of a busy clinic when nulliparous women may languish feeling faint and in pain following IUD insertion without local anaesthetic. In the training situation, if the instructing doctor first inserts the local anaesthetic then the training doctor can then proceed with the IUD or Mirena insertion in a much less stressful situation.

With this in mind, I asked a nulliparous woman last week following her second IUD insertion which was better: with or without local anaesthetic? She said that it was “a thousand times better” with local anaesthetic.

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Reference