Acute Trust for removal, where they still re-sterilise instruments.

Do the authors know of a source for the correct single-use instruments, or can a manufacturer be encouraged to develop the appropriate items?

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Reference

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Pharmacy-based sexual health services and clinical governance

I read with interest the Editorial by Beth Taylor in the July 2008 issue of the Journal. I agree that the time is right to develop vision to embrace additional providers of the sexual health service. The new pharmacist’s contract is a welcome development in this direction.

As Beth Taylor highlighted, there is certainly a need for educational and training support from other practitioners. Many community pharmacists have ever had the opportunity to observe an IUD insertion, aware that it was not a clinically simple procedure, stating “... nurses who are not necessarily need this level of observation. The RCN has been instrumental in the development of guidance in order to enable nurses working at a higher level within the area of contraception and sexual health to undertake the removal and insertion of intrauterine techniques (IUTs) and implants. Without this guidance, nurses who were performing these procedures, or who wished to do so, were opening themselves up to litigation should an error occur. The rationale behind the guidance stating five insertions is in the fact that some nurses (i.e. gynaecology nurses) may have ever before recorded the importance of an IUT fitting. It was always understood that those of us who had greater exposure to procedures would not necessarily need this level of observation.

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Reference

Underuse of the IUD

I read the article on the underuse of the intrauterine device (IUD) in the July issue with great interest and noted that none of the references are prior to 1983. That is 25 years ago, however the real blow to the IUD’s popularity was in the late-1970s when the Dalkon Shield® was pilloried and vilified as a source of pelvic infection, leading to what I believe was false scientific evidence. At that time there was a UK IUD network, organised by Professor R Snowden of Exeter University to which 20 major family planning organisations belonged.

Every device fitted and every subsequent patient visit was recorded and sent to Exeter. In 1977, over 40 000 fittings had been recorded, of which 7282 were Dalkon Shields. There were only two cases of pelvic infection and both were cases known to me in Glasgow: one in a prostitute with gonorrhoea and the other in a woman who had tried to abort herself with a knitting needle. As a direct result of organised adverse publicity the manufacturers of the Dalkon Shield went out of business and the reputation of all IUDs worldwide suffered a slump from which it has never recovered. A similar campaign against Depo-Provera® was mounted from the USA in the early 1980s and injectable methods never achieved the popularity they deserve due to commercial reasons.

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Reference

Treatment of perimenopausal menorrhagia with Implanon®

I write concerning the successful treatment of perimenopausal menorrhagia with Implanon® in a 53-year-old woman. The patient (date of birth early 1953) was seen at the surgery in October 2004 with symptoms of flushing and regular periods. In early 2006 she developed menorrhagia, which was investigated with normal hysteroscopy and intrauterine system (IUS) insertion in early August 2006. The IUS was expelled after 2 months in situ and after ongoing symptoms of polymenorrhagia. After some discussion with the patient regarding treatment options, she decided to trial Implanon insertion, aware that it was not a clinically recognised treatment option for menorrhagia. The insertion was carried out in early October 2006. On review in August 2008 the patient noted light bleeds in March and April 2007, and a 2-day light bleed in May 2008. She stated that she “would be willing to recommend Implanon to any fellow practitioner”. I plan to write to the manufacturer concerned, namely Organon, concerning this important clinical effect of Implanon in the treatment of perimenopausal uterine bleeding. I would be interested to hear if other practitioners have anecdotal evidence of Implanon being used in this way.

Let us to the Editor

Letters to the Editor are welcome and generally should not exceed 600 words or cite more than five references. For comments on material published in the most recent issue of the Journal, correspondence should be received within 4 weeks of dispatch of that Journal to be in time for inclusion in the next issue. When submitting letters correspondents should include their job title, a maximum of two qualifications and their address(es). A statement on competing interests should also be submitted for all letters. Letters may be submitted to the Editor or the Journal Editorial Office (details on page 205).