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
specialist disposable surgical instruments is
difficult, however we have good news.

Figure 1 Disposable vasectomy forceps used for Nonpant® removal

Reply

We thank Anne Bennett for her comments related to our article describing removal techniques for contraceptive implants.

Many manufacturers are bringing in single-use instruments policies as a result of new NHS guidance on decontamination aimed at improving the quality of surgical instrument reprocessing across the health care sectors in England. Finding manufacturers who are prepared to supply small numbers of specialist disposable surgical instruments is difficult, however we have good news.

Disposable modified vasectomy forceps can now be obtained for about £2 from the supplier mentioned below. This company is also making available surgical instruments for private patients who have undergone vasectomy.

Vasectomy forceps are now available with a choice of cutters and knifes.

Contact: Unisurge International Ltd, Unit N, Dales Manor Business Park, East Way, Sawston, Cambridge CB2 4JU, UK. Tel: 01223 839911. E-mail: info@unisurge.com.

Diana Mansour, FRCGP, FFRRH
Head of Service, Newcastle Contraception and Sexual Health, Graingerville Clinic, Newcastle General Hospital, Newcastle upon Tyne, UK. E-mail: Diana.Mansour@newcastle-pct.nhs.uk

Martyn Walling, FRCGP, FFRRH
General Practitioner, Spalding, UK. E-mail: martyn@belmontdoc.freeserve.co.uk

References

Dr. Bennett and I do not agree. The incorrect use of term Nonpant®, or even more commonly Nonpant®, which is the trade name of the forceps, can cause confusion for patients and practitioners. The term Nonpant® implies that these are the only forceps available for the removal of contraceptive implants. Many practitioners are familiar with a number of alternatives that are just as safe and effective.

However, regarding the question about the identification of the patient to be removed, I would recommend the use of a unique patient identifier, such as a patient ID number, to ensure patient safety and confidentiality. In addition, it is important to obtain informed consent from the patient to perform the removal procedure.

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 inflammatory disease, or PID, and on 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 and clinical research projects 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 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 deserved for their proportional commercial reasons. Women are ill-served by 'market forces'.

Elizabeth S B Wilson, MBBS, FFRRH
Family Planning Services Coordinator, Greater Glasgow Health Board 1980–1990, Glasgow, UK. E-mail: libby@wilson@doctors.net.uk

Reference

Nurse IUD fitting

We are writing to respond to the Personal View article by King and Dunster entitled 'Nurse intrauterine device training' that was published in the July issue of the Journal. We wholeheartedly applaud the positive experience expressed within this article, and this is in line with public health guidance where it is not necessarily need this level of observation.

The uptake of the newly launched online chargeable repeat contraception service will give an indication of clients' willingness to pay for such services.

Ranjana Rani, MRCGP, FFRRH
Consultant in Genitourinary Medicine and Lead Sexual Health, Tameside and Glossop Centre for Sexual Health, Tameside and Glossop Primary Care Trust, Denton, Manchester, UK. E-mail: rrani@nhs.net

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 other patients”.

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.

Liz Grant, MRCGP, DRCOG
General Practitioner, City Road Surgery, Hulme, Manchester, UK. E-mail: the.james.family@btinternet.com

Letters 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).

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