UK centres for Implanon® removal
Mea culpa – when writing the article on the UK
provision for removal of non-palpable contraceptive implants1 I forget to include Dr
Martyn Walling in Table 1. Martyn has the UK’s
greatest experience in removing deep implants
and is based at Waltham Forest PCT, Orchard House,
Greyleas, Sleaford NG34 8PP, UK. He is very
happy to accept written referrals sent to this
address. Martyn has also been working as an
independent practitioner, travelling the length and
breadth of the UK, training doctors to locate and
remove non-palpable implants.

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Reference

Editor’s note
An updated version of Table 1 in Dr Mansour’s article referred to above, which lists the UK referral sites for removal of
depo-provera contraceptive implants, appears on
page 85 of this issue of the Journal.

Contraceptive failure with Depo-Provera®
I have a concern regarding the recent case report
where a 28-year-old woman was given a subsequent (second) injection of Depo-Provera® by a
practice nurse when she attended after 13
weeks, and when no precautions were advised,
or occupation done. The patient subsequently
again reported with a positive
pregnancy test and opted for a termination of
pregnancy.1

My personal feeling is that although by and
large consultation times are often too short for
practising doctors to cover all aspects of
counselling at all times, when a patient is using a
contraceptive method outside the terms of the
product licence, to ensure that optimal service is
offered and also in view of the remote possibility
of litigation following failure of the method, it
should be the practitioner’s
primary responsibility to get involved and appropriately counsel, and to adequately document such an episode.2,3

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References
1 Farmer L, Patel E. Contraceptive failure of Depo-
3 Fazal S. FSH and Reproductive Health Care Clinical Effectiveness Unit. FFSRH Guidance (July 2005). The use of contraception outside the

Reviewing the National Sexual Health and HIV Strategy
In response to the article entitled ‘Reviewing the National Sexual Health and HIV Strategy’
published in this Journal,1 I would like to endorse the
authors’ comments with regard to the lack of
standardised training for nurses in reproductive and
sexual health care. As an educator in a Higher
Education Institute (HEI), with experience of
contributing to developing national education and
training initiatives, I would like to express similar
frustrations with the lack of national standards in
sexual health training for nurses. With the increasing
pressures on resources, HEIs must
develop innovative solutions to meet the sexual
health education and training needs of nurses.
Providing access to education for such a national ’e-learning’ course could be one solution to meeting the standards in reproductive and sexual health service delivery.

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Reference

Reviewing the National Sexual Health and HIV Strategy
I write in response to the article entitled ‘Reviewing the National Sexual Health and HIV Strategy’, published in the October 2008 issue of this Journal.1 I would like to applaud the authors’ comments within this article relating to the lack of standardised training for nurses in reproductive and sexual health care. Since the demise of the National Boards, nurses and their employers have been left in a very unhealthy void as they are unable, with confidence, to ensure that either the training they are receiving, or the training that has been undertaken, is robust enough to provide the preparation of consistent, effective and evidence-based advice to clients. At least when a nurse presented with the (e)NBN course certificates you knew what you were getting. I worry that many other nurses, and employers of nurses, would be overjoyed to see the new DFSRH online learning programme being able to be accessed and accredited for nurses as the new ‘gold standard’ for training in this area.

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Reference

Sexual health of South Asians in the UK
I was interested to read the comprehensive review article by Dr Sunanda Gupta in the
May issue discussing the wide range of sexual knowledge and behaviour, contraceptive
behaviour, and sexually transmitted infections (STIs) and HIV in the South Asian population.
There is very scant if any information on ethnicities and abortions. Though abortion
statistics have been available from 1968 from the Registrar General and from 1974 from the Office
for Population Censuses and Surveys
OPCS/Office of National Statistics
ONS, it was not until 2005 that ethnicity was included in data
collection. Our unpublished data in Waltham Forest (for 2006) show that a total of 1257
abortions, >50% of abortion requests were from women
with the lowest positivity are consistent with ethnic variations in sexual behaviour noted in the National Survey of
Sexual Attitudes and Lifestyles (Natsal 2005),5 we should also consider that the differences
observed to date may be influenced by other factors. For example, screening is not yet national and
may be missing areas and local ethnic groups with higher/lower positivity. Differences in health care-seeking behaviour/service access
to ethnic groups will also mean some groups are-screened more than others.5

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References
2 Health Protection Agency. Sexually Transmitted Infections in Black African and Black Caribbean
3 Berthoud R. Teenage births to ethnic minority women Trend 2001; 104: 12–17.

Reply
We thank Dr Sunanda Gupta for comments relating to our review of the National Sexual
and reproductive health of South Asians in the UK.1

We agree there is a paucity of detailed data on ethnicity and abortion and on ethnicity and teenage births. In 2002, the abortion notification form
(HSA4) was used for the recording of ethnicity, as self-reported by the women involved. This information was not previously recorded. In 2007, of the 198 499 legal abortions that were recorded, 75% of women reported being white, 11% black or British, and 8% Asian or Asian
British. Interestingly, the percentage of previous abortions (where the woman has had one or more previous abortions in addition to the one recorded
for 2007) also varies by ethnicity. Of those women having abortions in 2007, 31% of white, 48% of black/black British and 28% of Asian
women, had previously had an abortion.2

In terms of teenage births, Berthoud’s 2001 data relate to the 1980s and early 1990s and show that Bengali and Pakistani women had
higher rates of teenage motherhood (with a majority of births within marriage) compared to white women. Although often culturally acceptable for these ethnic groups when within marriage, teenage motherhood nevertheless have socioeconomic and educational implications. More recently, however, there has been a marked decline in early parenthood in South Asian groups in all ethnic groups having lower than average incidence of teenage motherhood.3,4

Expanding upon the data presented by Dr
Gupta on the National Chlamydia Screening Programme (NCSP), there are clear differences
between ethnic groups in terms of positivity. Groups with the highest positivity include those of mixed, black Caribbean and other black ethnicity and those with the lowest positivity include those of Chinese and Asian/Asian British origin.5 Although the observed differences in positivity are consistent with ethnic variations in sexual behaviour noted in the National Survey of
Sexual Attitudes and Lifestyles (Natsal 2005),5 we should also consider that the differences
observed to date may be influenced by other factors. For example, screening is not yet national and
may be missing areas and local ethnic groups with higher/lower positivity. Differences in health care-seeking behaviour/service access
to ethnic groups will also mean some groups are-screened more than others.5

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References
2 Health Protection Agency. Sexually Transmitted Infections in Black African and Black Caribbean
3 Berthoud R. Teenage births to ethnic minority women Trend 2001; 104: 12–17.
4 Sunanda Gupta, FRCOG, FFSRH
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In both cases, when the removed IUS was re-examined, it became apparent that the entire device had been removed from the uterine cavity. The arms were still attached to the main stem of the IUS. The hormone release capsule, usually situated at the base of the vertical stem, had migrated up the shaft, trapping the arms in the capsule, making it appear as if they had been detached (Figure 1).

The majority of IUS are removed without difficulty. There are no published cases of IUS arms becoming detached. However, an intrauterine-retained hormone release capsule following IUS removal has been documented.2

The common theme in the two patients described above and Forrest et al.'s patient is difficult retrieval of the device requiring more traction on the threads than normal. This presumably led to the capsule being dislodged, either migrating up the device and getting stuck covering the arms or becoming detached altogether. Clinicians should always check IUS devices after removal. They should also be aware that after a difficult removal the capsule can migrate and obscure the arms but the device remains complete. Knowledge of this possibility will prevent patients being subjected to unnecessary investigations and interventions to find ‘missing’ IUS arms and for appropriate investigations and interventions when the capsule has detached completely.

The whole of the IUS device is radio-opaque and can be located with either X-ray or ultrasound.2 Transvaginal ultrasound is the first-line investigation of choice. It provides the best images to help determine whether or not the IUS is correctly sited within the uterus. The vertical stem of the IUS is visualised in the sagittal plane with multiple reflective parallel planes and in the axial plane as a single echogenic focus.3

However, in the cases reported here the vertical stem was missing. Horizontal arms are rarely seen in the uterus unless it is possible to obtain a coronal view.3 In view of this difficulty abdominal X-ray would confirm whether or not the horizontal arms of the IUS were within the pelvis. This would be useful, especially prior to embarking on hysteroscopic investigation.

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References
2 Schering. Contra-indications, warnings, etc. Mirena Insertion Instructions, June 2007.

Reply
We would like to take the opportunity to respond to Dr Torbé et al.’s letter.1

An extremely rare, isolated case report of hormone cylinder dislocations in the Mirena® intrauterine system (IUS) similar to the ones described by the authors have been received by the company’s Pharmacovigilance and Quality Assurance Unit. The company’s investigations have shown that these cases could not be attributed to a quality defect of the product.

Difficulty removal has been found as the underlying cause, and no further adverse effect in the Mirena user are mentioned in the majority of cases.

To make physicians aware of this extremely rare situation, and to avoid unnecessary interventions in search of ‘missing’ Mirena arms, the company has recently introduced the following statement into the upcoming Material Information for Mirena®: “After removal of Mirena®, the system should be checked to be intact. During difficult removals, single cases have been reported of the hormone cylinder sliding over the horizontal arms and hiding them together inside the cylinder. This situation does not require further intervention once completeness of the IUS has been ascertained. The knobs of the horizontal arms usually prevent complete detachment of the cylinder from the T-body.”

Implementation of this statement into the local product information is currently ongoing in all countries where Mirena is marketed, and it was submitted at the beginning of December 2008 to the Medicines and Healthcare products Regulatory Agency (MHRA) to be implemented in the UK.

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Reference

Serious morbidity with long-term IUD retention

We have recently encountered four patients with serious intraperitoneal sepsis over an 18-month interval (2007/2008). Each was associated with long-term retention of a copper intrauterine device (IUD), which was identified as the likely source of infection. The IUDs had been in situ for 8, 15, 18 and 20 years, respectively. Three women were several years into their menopause. All four women presented as systemically unwell with a complex pelvic mass. One had uterine obstruction at the site of the abscess, simulating gynaecological malignancy. In all cases laparotomy was technically difficult owing to the inflammatory pelvic mass adhering to bowel. Intermediate or prolonged hospitalisation resulted and, without invasive device care, two of the women would probably have died.

Pelvic actinomycesc was reported in the two patients’ histology. Cultures of frank pus grew Actinomyces israelii in the third. Actinomyces-like organisms (ALOs) had been reported in gynaecological smear of the fourth woman. In 2004 she had undergone appendicectomy, which showed