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severe subserosal inflammation without mucosal inflammation leading to the conclusion that the source was elsewhere within the abdomen or pelvis. It is speculative that this episode 4 years earlier may have resulted from the long-term presence of her IUD. Pelvic actinomyces normally begins as subacute or chronic disease, months or years before presentation.

Intrauterine contraceptive devices marketed in the UK have licensed durations of 5, 8 or 10 years. In women aged under 40 years it is recommended they are changed according to licence. If inserted after the age of 40 years the device may remain in situ until 1 year after the menopause if the last period (LMP) is over the age of 50 years, or 2 years after if the LMP is under the age of 50 years.2 These recommendations are based on expert opinion and acknowledge that insertion-related risks are minimised by reducing the frequency of IUD changes. National guidance places strong emphasis on when removal is safe from a contraceptive point of view.3 There is no clear mention of the need for removal once the contraceptive action is no longer required, or of the risks of failing to do so. The frequency with which ALOs are reported in routine smears rises in a linear fashion with the duration of use of devices.4 ALOs are more common with certain types of copper IUD5 and uncommon with the levonorgestrel intrauterine system.6 Pelvic actinomyces is an uncommon and poorly understood condition, but has been recognised to complicate IUD use since the first report in 1973. However, Actinomyces also normally reside in the female genital tract.2

We cannot provide any denominator data for the denominator of women in the catchment population with a long-term IUD, but the occurrence of a cluster of cases of serious intraperitoneal sepsis in a single hospital in a relatively short space of time is unusual. It is likely that single cases are not reported, or the association with the copper IUD overlooked, by surgeons and not fed back to those providing contraception services. When a pelvic mass or abscess, fever and other signs of infection are found in patients with a long-term IUD, pelvic actinomyces should be considered. Awareness of this could usefully be increased among general surgeons and gynaecologists. We recommend that current guidelines be revised to include some emphasis on the importance of timely removal of an IUD, once its contraceptive properties are no longer required. Women should be made aware that long-term retention may rarely result in serious sepsis with pelvic actinomyces and/or actinomyces. There should be more emphasis on timely removal of an IUD early in the menopause. This is not included in existing professional guidance2 and patient information leaflets.5

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Reply

With regard to the four cases of serious pelvic infection described by Pillai et al., the Clinical Effectiveness Unit (CEU) and Consultant in Sexual and Reproductive Health, Cheltenham, UK. Your Guide to the IUD. London, UK: FPA, October 2007.

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IUS producing a TAC

I recently saw a very unusual patient in whom an intrauterine system (IUS) appeared to produce a trigenomal aechenial cegom (TAC).

The patient, a 39-year-old woman, was fortunate to never have had a headache until the events reported here. In early 2007, the patient started to complain of severe menorrhagia. Her periods were lengthy and heavy and lasted for up to 14 days, and necessitated the use of 15–20 sanitary pads a day. Tranexamic acid 1000 mg qds was tried initially for 8 weeks but the heavy bleeding continued. Not being contraceptive users, the copper IUD was tried for many months resulting in a mild improvement. In desperation, the patient was referred to a gynaecologist who felt that the next step was to try a new levonorgestrel-releasing IUS. This was duly done. Within 6 hours of inserting the IUS the attacks started. All the patient’s attacks (averaging 5–7 attacks/day) were similar. All were left sided and very intense. An attack started with pain to the side of the left eye that the patient described as unbearable, like the worst toothache ever. Associated with the pain was painless tearing from the left eye, although the pain was so bad the patient also cried with right eye. Her palpbral fissure narrowed, her nose ran and her eye became pink. Her face felt strange and numb though painful. Touching her face, or brushing her hair or her teeth, did not trigger an attack. The attacks continued daily for 4 weeks until the patient came to see me.

As she entered the room, an attack started. Following the attack I removed the patient’s IUS very easily and gave her a zolmitriptan nasal spray. In case I missed anything she would never, even for the purposes of research, have an IUS inserted again.

This woman appeared to develop a TAC, which approximated most closely to a cluster headache. The patient had had headaches for many years, and experienced many different attacks. They started with pain in the side of the left eye, and would be rapidly cured by removing the device. I would be delighted to discover if any of the Journal’s readers have observed a similar case.

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Informed consent for IUD fitting

Perforation of the uterus is a rare complication of intrauterine device (IUD) fitting. It is quoted as occurring in 1 per 2000 to 1 per 5000 IUD fittings.1 Risk factors for perforation include previous caesarean section2 and postpartum insertion up to 6 months after delivery.3 Conception may occur during the sounding of the uterus or the device itself may perforate the uterus. This can lead to the device being free in...
the abdominal cavity, necessitating removal by laparoscopy or laparotomy. Faculty Guidance tells IUD fitters that they should explain the risk of perforation to women considering an IUD and document this discussion in the clinical record. This fits with General Medical Council (GMC) guidance on informed consent.

I dealt with a complaint from a woman who had a perforation of the uterus following an IUD change; this lady required laparoscopy to remove a missing IUD. The perforation was diagnosed at her IUD check, when the threads were found to be missing. Despite a clinical record showing “perl” followed by a tick this lady alleged that she had not been made aware of the risk of perforation and that if she had been aware she would not have had an IUD fitted.

Dealing with this complaint led me to review my own clinical practice and to seek the opinions of other IUD fitters. Using a questionnaire, 15 instructing doctors were asked about the manner in which they (1) explain perforation risk to women and their confidence doing this and (2) assess their patients’ understanding of the risk of perforation.

These doctors all explained the risk of perforation to all women on their first IUD fitting but only 80% did on subsequent fittings. They commonly used an explanation along the lines of: “There is a small chance – 1 in a 1000 – of perforation. This means making a hole in the wall of the womb. This is not serious but if the IUD goes into the tummy outside the womb it has to be removed with keyhole surgery”. An explanation such as this would meet GMC consent guidance (i.e. you must tell patients if an investigation or treatment might result in a serious adverse outcome, even if the likelihood is very small). Although 50% of doctors found perforation easy to explain only 20% felt that their patients had understood the risk of perforation. If this is the case then this would not meet guidance that "you should check that a patient understands the terms that you use, particularly when describing the seriousness, frequency and likelihood of an adverse outcome". No doctor felt that patients were deterred from having an IUD fitted by the risk of perforation. More than 50% of the doctors felt that they would like further training in the discussion of risk of perforation of the uterus and of explanation of risk in general.

It sometimes takes a review of everyday practice to identify a learning need. In this case it was prompted by a complaint from a woman who unfortunately did experience uterine perforation following an IUD change. All the doctors questioned did discuss the risk of perforation at a first IUD fitting but not all did at a subsequent IUD change. We should not assume that a woman will remember the potential complications of IUD fitting from a previous consultation.

The management of this particular complaint and the results of this survey have changed the way in which I discuss perforation risk with women, and I now incorporate this into a fuller explanation of how the device is introduced and explaining of how the device is introduced and why a problem might occur potentially leading to perforation.

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References

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 69).

Journal of Family Planning and Reproductive Health Care Statement on Duplicate (Redundant) Publication

The January 2003 issue of the Journal of Family Planning and Reproductive Health Care included an article entitled:


This article overlapped considerably with an article in the February 2003 issue of STI, namely:


The reasons for this are complex and are detailed on the Committee On Publication Ethics (COPE) website (http://publicationethics.org/annualreport/ombudsmansreports). This does not reflect on the scientific validity of either paper.

Anne Szarewski, PhD, FFSRH
Editor-in-Chief, Journal of Family Planning and Reproductive Health Care