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.[4]

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 "perf" 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).[4]

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 why a problem might occur potentially leading to perforation.

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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:

Underhill G, Hewitt G, McLean L, Randall S, Tobin J, Harindra V, *et al*. Who has chlamydia? The prevalence of genital tract *Chlamydia trachomatis* within Portsmouth and South East Hampshire, UK. *J Fam Plann Reprod Health Care* 2003; **29**(1): 17–20.

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

Pimenta JM, Catchpole M, Rogers PA, Hopwood J, Randall S, Mallinson H, *et al*. Opportunistic screening for genital chlamydial infection: II: Prevalence among healthcare attenders, outcome, and evaluation of positive cases. *Sex Transm Infect* 2003; **79**: 22–27.

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.

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