levonorgestrel for emergency contraception: a
randomised non-inferiority trial and meta-analysis.

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Letters to the editor

7 Cheng L, Gülmezoglu AM, Piaggio G, Ezcurra E, Van
2,3 Studies have also demonstrated that
ovulation whereas LNG is no better than
when given at mid-cycle (when risk of
1. There is clear evidence that ulipristal acetate
following points:
clinics with the intention of trying to induce an
at emergency contraception.
Health Service abortion services may try to
appropriate that a European pregnancy registry

In response to the letter1 from Drs Pittrof,
3 Croxatto HB, Brache V, Pavez M, Cochon L, Forcellecillo ML, Alvarez F, et al. Pharytitic-ovarian function and
upregulation levonorgestrel emergency contraceptive dose or a single 0.75 mg dose for
luteal dose of the selective progesterone receptor
Glyburide and Levonorgestrel, Women’s
Healthcare (UKMEC) have changed their guidance but
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In conclusion, we welcome a paper that aims to
improve patients at the time of the care
caring ways to reduce waiting time, but could
guard against overenthusiastic claims.
Evelyn Kerr, MBCOG
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Reproductive Healthcare, Southwark Primary Care Trust, London, UK.

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1 Hitchings S, Barter J. Effect of self-triage on waiting times at a walk-in clinic for emergency ovulation.
modulator for
emergency contraception: a randomized controlled

9 HRA Pharma UK Ltd. ellaOne 30 mg: Summary of
org/medicine/22280/SPC/ellaOne+30+mg/+Accessed+4+February+2010.
10 Croxatto HB, Brace V, Cochon L, Jesam C, Brache V, Cochon L, et al; the PRM raise issues for service delivery and for
reproductive rights. We therefore welcome a study that aims to
examine the impact of self-triage on waiting times and identify factors
that may help to reduce the delays experienced by women.

In conclusion, we welcome a paper that aims to
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Combined pill and GTD
I have read the new UK Medical Eligibility
Criteria for Contraceptive Use (UKMEC) guidelines1 and am surprised and concerned that the
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suggest that this was not in the patients’ best interests given that it contradicts the advice of the RCOG and the Charing Cross Hospital GTN website.

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Resolution of localised lipoatrophy at the site of Implanon© insertion

I have previously reported a 40-year-old woman who had had an Implanon© implanted into her right upper arm.1 At the site of the Implanon in the middle of the inner aspect of her right upper arm it was noticed at the time of implant removal 3 years later that she had a localised area of lipoatrophy extending approximately 2 cm either side of the implant and along a length of approximately 15 cm extending above and below the end of the implant. In this 4 x 15 cm area there was virtually no subcutaneous fat. The lipoatrophy had been asymptomatic and had had no effect on the patient who had had to have the area of lipoatrophy demonstrated to her.

Six months after removal the area of lipoatrophy had completely resolved and the patient remains asymptomatic. Both arms looked the same with the return of the subcutaneous fat on the affected side. It has been suggested2 that lipoatrophy might have been caused by the long-lasting effects of topical steroids but a review of the patient records shows they have not been prescribed over the last 8 years and the resolution of the lipoatrophy after removal of the implant does suggest Implanon© as a cause.

I suggest that localised lipoatrophy is added to the rare side effects described for Implanon and that the possibility of it developing, even if it is reversible, further motivates correct placement of the implant.

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1 Lindsay P. Localised lipatrophy at the site of Implanon© insertion [Letter]. J Fam Plann Reprod Health Care 2009; 35: 266.

Use of an expired Cu-IUD

I was ready to fit an intrauterine device (IUD) in the CASH clinic when the nurse announced that the expiry date of the Flexi T-300© was 6 months previous. Having already opened the pack, I continued to fit the IUD to save National Health Service (NHS) money. I do not know if many years ago at an update conference I had heard an expert panel state that it is safe to use an IUD up to a year after the expiry date. Common sense dictates that an expired Cu-IUD is not the same as expired sandwiches, for example. Shortly after this episode occurred I was on annual leave. During my holiday, one of my colleagues contacted the patient and subsequently replaced the IUD, informing the patient that there was a risk of pregnancy. I was surprised at this since I am aware that there are a number of problems associated with IUD fitting and removal per se. One could argue that the IUD could have been left in situ for 4.5 years instead of the normal 5 years.

I would be interested to know whether any other Journal readers have used an expired IUD and, if so, what the outcome was. Was my colleague right to replace the IUD on this occasion?

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Reply
I would like to respond to Dr Yadava’s letter1 on behalf of Williams Medical Supplies, a manufacturer of copper intrauterine devices (IUDs). Most Cu-IUDs have an expiry date of around 4 years. This is because the sterility can be guaranteed over this time frame. Once the expiry date has passed, the product is no longer guaranteed to be sterile and therefore we would not recommend fitting an expired IUD in a patient because of potential infection concerns. If an expired product is fitted by mistake, then there are two courses of possible action. One would be to undertake a close patient observation over an agreed time span to ensure infection has not occurred. The second option would be to remove the IUD and fit a new one that is within its expiry date.

April Jones
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E-mail: april.jenkins@wms.co.uk

References

Reply
I would like to respond to Dr Yadava’s letter1 on behalf of the Clinical Effectiveness Unit of the Faculty of Sexual and Reproductive Healthcare. We are not aware of any evidence or...