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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References

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 axis along a length of approximately 15 cm extending above and below the ends 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 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 return of the subcutaneous fat on the affected side. It has been suggested2 that lipoatrophy might have been caused by local steroid or hormone therapy 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 not support this 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, is further motivates correct placement of the implant.

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References
1 Lindsay P. Localised lipoatrophy 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 and I have no evidence that 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 approximately 5 years. This is to allow for the possibility of a future change of sterilization that cannot 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 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.

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Reference

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...
recommends that intrauterine devices (IUDs) are safe to use after the manufacturer’s expiry date. Guidance from the Medicines and Healthcare products Regulatory Agency (MHRA), however, states that the interruption of the manufacturing process for which this information is intended, is advised that an IUD is used only if the sterile package has not expired. Therefore, Dr Yadava’s patient was probably not a contraceptive for efficacy but she may have been at increased risk of infection. In the event of inadvertent insertion of an expired IUD, the patient should be informed of the error and advised of the risks of retaining or replacing the IUD. If the IUD has only recently expired or if the IUD has been inserted without any infective complications, then the risks of replacing the IUD may outweigh the benefits. Confusion has possibly arisen because in contraceptive literature the term ‘expiry date’ is often used to describe the limit of an IUD’s recommended duration of use. This ‘expiry date’ can be exceeded in women who are over the age of 40 years at the time of insertion.1


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Letters to the editor

Correspondence about the recent article on “Nurse Training in Sexual and Reproductive Health”

The Journal has received a number of letters written in response to the Personal View article entitled Nurse training in sexual and reproductive health by Shelley Mehigan, Wendy Moore and Linda Hayes that appeared in the January 2010 issue of the Journal. The very fact that this article has attracted the greatest number of letters to date written in the Journal in recent years is evidence of the article’s timeliness and relevance to many of the Journal’s readers. The individual letters received by the time this correspondence went to press, and the responses from Shelley Mehigan and Wendy Moore, are reproduced here in full.

Letters

I would like to thank the authors of the article1 on nurse training in sexual and reproductive health in the January 2010 issue of this Journal for very clearly setting out the current situation regarding nurse training in this specialty and the history to the situation. I agree with the authors that post-registration training in sexual and reproductive health has been an area of concern for some years now. Certainly when I joined the Faculty Associate Members Working Group 3 years ago this was one of our main agendas. We were looking at what nurses could do the Faculty Diploma (the DFFP as it was known then) along with doctors. This was not possible as it is a medical diploma and qualification. This has come full circle and will be revisited. A lot of work has taken place in this group, including attempting to map current training provided across the country.

1. Recommendations. As a Senior Nurse Manager in a service employing over 60 SRH nurses I find the lack of standardisation of training difficult when recruiting; to ascertain from applications whether the candidate has completed a recognised training or if a skills course can be difficult, in addition ‘recognised’ courses can vary significantly. From the nurse’s point of view there seem to be enthusiastic candidates who have not attended an adequate or even a recognised sexual health courses but who are keen to move into the specialty and it seems some nurses are having difficulty in knowing exactly which training is required by employers and/or accessing the training.

2. Access to training. From the nurse’s position, to undertake a contraception and sexual health course at a Higher Education Institute (HEI) can take 3–9 months to complete. Managers are reluctant to give study leave to enable nurses to access the training, and nurses are struggling for time to undertake any one of the modules of the job with lengthy assignments. In some instances, after 6 months two modules have been completed and the nurse is trained in contraception; however, the nurse is required to complete cervicai cytology screening and yet another for management of sexually transmitted infections (STIs). A multi disciplinary training. I believe that training in contraception and sexual health should be multidisciplinary. Nurses and doctors should be able to access the same training and undergo the same assessment; it would follow on that standard accreditation is required. The Faculty has welcomed Associate Members with the AMNG working group and with Associate Members represented on other committees. If the Faculty could extend accreditation to clinicians other than doctors this could address many of the issues, although this is currently not possible.

3. Standardised training. The content of the training must be standardised and it is vital that training from all providers and HEIs is up to date, evidence-based and reviewed by practising experts in SRH. The course should cover contraception and sexual health to meet the needs of integrated services. Cytology training and updating is an important part that would benefit from standardising across disciplines.

4. The new e-learning of the DFSRH will be accessible for all to learn in their own time and at their own pace. Assessment would be standard. The Course of 5 may be richer for having doctors and nurses training together. I believe the clinical placement and clinical assessment is a very important part of the SRH nurse training and I would not like to see it reduced. This part of the assessment is not undertaken by HEIs but by local SRH departments. Therefore this could continue with the new e-learning and be doing a university-accredited course. Locally we provide clinical placements of 12–14 weeks with usually one session a week. If this can be provided with longer sessions in a shorter time period then the clinical training could be completed in several weeks.

5. Many post-registered nurses are not doing the contraception and sexual health training as part of a pathway to get a degree, but to achieve the competencies required to work in the area. For those nurses who choose to do it as part of a degree or as a short course which should be available at HEIs but I would recommend that the course includes the same basic content as the standard training accessed by doctors and nurses (i.e. the Training, Course of 5 and clinical placement).

Accreditation needs to be addressed urgently in view of the Royal College of Nursing (RCN) changes. We plan in future to provide accreditation as a Department of SRH to nurses training in the sub-disciplines (SDs). However, this has implications for those who wish to become primary trainers for their medical colleagues.

Rosie Jackson

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References

I am corresponding in response to the article1 in the Journal on nurse training in SRH, and want to say that I totally agree with all of the points the authors raised in this article.

I am the lead nurse for sexual health in Northamptonshire Healthcare Foundation NHS Trust with 27 family planning (FP) nurses and 23 genitourinary medicine (GUM)/HIV nurses. Training, education and development of their roles is one of my key responsibilities.

In the days of the English National Board (ENB), as the authors quite rightly say, we knew the standards required. Currently we support FP students on courses at De Montfort University Leicester and are very satisfied with this course in terms of standards and support from tutors, and so on. However, there have been students from other areas who have found the course less than impressed with the course offered.

I think the proposal to link in with the DFSRH standards is an excellent progression, particularly as nurses take on such an integral advanced role in this specialty. With advanced practice, as I manage to know that when a new member of staff has attended specific courses, it is at the level required to carry out the job competently and safely.

I welcome involvement in these new initiatives.

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Reference

I was most interested to read the nurse training article1 in the Journal. I have a particular interest in nurse training as one of my roles at The Margaret Pyke Centre is Nurse Trainer for inserting and removing subdermal implants. I am also training to be a Faculty Nurse Trainer for Doctors in this specialty.

It seems to me that the Royal College of Nursing (RCN) are implementing policies that potentially discourage these Trainees, by the large increase in accreditation and re-accreditation fees. Primary care trust budgets seem to be tight that they are not providing the money for the fees, so that the only way for a nurse to obtain accreditation is to pay for it herself. The nurses that I have trained have had difficulty in affording the fee of £35 (£75 for non-RCN members), so you have a situation that a fee of £300 (£400 for non-members) is going to cause. It is definitely going to reduce the number of nurses coming forward for the programme. Furthermore, this disincentive to increasing the pool of competent people is contrary to the stated policy of promoting long-acting reversible contraception (LARC).