Progesterone receptor modulators
The review on ‘Progesterone receptor modulators in gynaecological practice’ in the April 2010 issue of the Journal is a valuable contribution to the literature on a currently important subject.

In the section on ‘Contraception’ the authors have dealt at length with mifepristone. Since the latter is not licensed for postcoital contraception, it seems inappropriate to discuss it if the authors dealt with some salient features of the recently introduced second-generation selective progesterone receptor modulator, ulipristal acetate, which is licensed for postcoital contraception for up to 120 hours after unprotected sexual intercourse.

The primary mechanism of action is inhibition of ovulation, but alterations in the endometrium also have anti-implantation effects. Ulipristal acetate appears to be a more potent inhibitor of ovulation than levonorgestrel and hence may be relatively more effective as a method of postcoital contraception.1-3

While the post-implantation use of levonorgestrel has not been associated with any harm, as yet the timeline for when it has not been established for ulipristal acetate.4

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References
3 Croatto H, Brache V, Pauzis M, Cochin L, Forcellini F, et al. Prolyl-4-hydroxylase activity following the standard levonorgestrel emergency contraceptive dose or a single 0.75 mg dose given on the days preceding ovulation. Contraception 2004; 70: 442–450.

Nurse training in SRH
I have just read the Personal View1 on ‘Nurse training in SRH’ in the January 2010 issue of the Journal and I agree with most of what Shelley Meghan and her colleagues have written.

It would seem sensible that sexual and reproductive healthcare (SRH) training is unified for doctors and nurses. Full membership of the Faculty of Sexual and Reproductive Healthcare (FSRH) should be open to both. Nurse practitioners should be allowed to undertake the same training and sit for the Letters of Competence (LoCs), Diploma of the FSRH (DFSRH) and Membership of the FSRH (MFSRH). SRH, in particular, is ideally suited for such progress. Increasingly, nurse practitioners are providing Level 1 and Level 2 services and doing the bulk of the routine clinical work.

The Meghan et al. article did not mention that several Colleges already allow other health care practitioners to undertake their training and examinations. I am sure that readers are well aware of this; here are some good examples.

1 Faculty of Public Health of the Royal College of Physicians
Other health care professionals, in addition to doctors, may undertake the full training in public health and then be placed on the Voluntary Register of public health practitioners. They can take the MPFP (Membership of Public Health) examination. They may be appointed as Consultants in Public Health and interestingly can act as public health practitioners.
2 Royal College of Pathologists
Training and Membership of the Royal College of Pathologists (MRCPath) is open to scientists, such as virologists and biochemists, and they are not necessarily required to have a medical qualification.

3 Royal College of Surgeons of Edinburgh
The DIMC (Diabetes in Medical Colleges of the Royal College of Surgeons of Edinburgh) is open to doctors, nurses and paramedics working in this field.

4 Society of Apothecaries
The Royal Charter of the Royal College of Apothecaries of London (RCAPh) states the purpose is: “The encouragement of the study and the advancement of the science and practice of pharmacy and apothecary and gynaecology”. This is a broad definition and should allow the ROCG and the FSRH to take a progressive view of joint training.

In conclusion, I fully support the Personal View article and would be happy to discuss it further with the authors. I will also be interested to hear about future progress on this issue.

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Reference

Need for IUD fitters to have expertise in resuscitation
I was pleased to read the Personal View article on ‘Nurse training in SRH’ in the January 2010 issue of the Journal.

We have a related issue at the moment with the introduction of new intrauterine devices (IUDs/IUSs) with no doctor present. Indeed we have very few doctors in such clinics.

None of us have ever canivated or given IV drugs (including me for over 20 years). Some people have taken blood from time to time but none of us have any need to do so regularly. We are protected to be able to do so to such extent that we would involve weekly IV drug administration/cannulation, which would remove us all from clinic to theatre or similar to do so. Our resuscitation department is amazed by the guidance.

We surely cannot be the only family planning unit that has predominantly nurse-led clinics, and I cannot believe all IUD fitters have extensive expertise.