Progesterone receptor modulators

The review 1 on ‘Progesterone receptor modulators in gynaecological practice’ in the April 2010 issue of the Journal is a valuable contribution to the gynaecological 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 is important that the authors deal 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.5 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.3-5

While the post-implantation use of levonorgestrel has not been associated with any harm other than the disadvantage that the NICE has not established for ulipristal acetate.6

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References
5 Cameron S, Glasser A. The need to take a ‘new look’ at emergency contraception, J Fam Plann Reprod Health Care 2010; 36: 3–4.

Nurse training in SRH

I have just read the Personal View 1 on ‘Nurse training in SRH’ in the January 2010 issue of the Journal and I agree with most of what Shelley Mehigan and I am happy to reiterate. 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 Mehigan et al. article did not mention that several Colleges already allow other health care practitioners, such as nurse training and examinations. I am sure that readers are well aware of this; there 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 Examinants. They then take the MFPH (Membership of Public Health) examination. They may be appointed as Consultants in Public Health and interestingly can act as nurse 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 (Diploma in Immediate Medical Care) of the Royal College of Surgeons of Edinburgh is open to doctors, nurses and paramedics working in this field.

4 Society of Apothecaries
The ROCSA (Diplomate in the Forensic and Clinical Aspects of Sexual Assault) is open to nurses and midwives as well as doctors. This particular diploma is very relevant to SRH practice. The DMCC (Diploma in the Medical Care of Catastrophes) is also open to nurses as well as doctors.

5 University diploma
Many of the University diplomas are open to a wide range of health care professionals [e.g. the Diploma in Palliative Care of the University of Edinburgh (nurses, doctors) and the Diploma in Medical Law of Northumbria University (nurses, managers, lawyers, doctors)].

6 Medical Royal Colleges and Nurse Training
There should be no great impediment to the Medical Royal Colleges working more closely together with the RCN and universities on unified nurse and doctor training in shared fields.

The Royal Charter of the Royal College of Obstetricians and Gynaecologists (RCOG) states the purpose is: “The encouragement of the study and the advancement of the science and practice of obstetrics and gynaecology”. This is a broad definition and should allow the RCOG 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 1 article on ‘Nurse training in SRH’ in the January 2010 issue of the Journal.

We have a related issue at the moment and we would like to seek comments from other Journal readers. It concerns the Faculty’s guidance on resuscitation for nurses when fitting IUDs.2 It suggests someone competent to give intravenous (IV) drugs must be available. The Royal College of Nursing (RCN) has also made a statement3 supporting this but when contacted the RCN said it supported it because it was Faculty guidance and didn’t seem to understand the consequences or practicalities. It would appear that there is no named person to discuss this matter with there.

We currently have nurse-led community clinics that provide intrauterine devices (IUDs/IUSs) with no doctor present. Indeed we very few doctors in such clinics.

None of us have ever canulated 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 not doctors, and I don’t believe to do so would involve weekly IV drug administration/cannulation, which would remove us all from clinic to clinic or theatre to similar to do so. Our resuscitation department is amused 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

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