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 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 not clear how this could be interpreted if the author 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 may be relatively more effective as a method of postcoital contraception.\(^{1,2}\)

While the post-implantation use of levonorgestrel has not been associated with any harm, an as yet the losette has not been established for ulipristal acetate.\(^{3,4}\)

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References

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 Meghan and Barbara O’Brien write in their View.

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 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 (FPH)

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 can take the MFPH (Membership of Public Health) examination. They may be appointed as Consultants in Public Health and interestingly can act as ‘Lead’.\(^{3}\)

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 DMC (Diploma in Medical Care of the Elderly) in Edinburgh is open to doctors, nurses and paramedics working in this field.

4. Society of Apothecaries

The DipCASA (Diploma 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 Cardiff University (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 Obstetrician 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 your Personal View\(^{1}\) on ‘Nurse training in SRH’ in the January 2010 issue of the Journal. We have a related issue at the moment and would welcome comments from others. It concerns the Faculty’s guidance on ‘Nurse training in SRH’ in the January 2010 issue of the Journal.

None of us have ever cannulated 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 advised that to be competent to do so would not necessarily require to have a medical qualification.

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

©FSRH J Fam Plann Reprod Health Care 2010; 36(3): 179

LETTERS TO THE EDITOR

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