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 important to note that 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 hence may be relatively more effective as a method of postcoital contraception.1-5

While the post-implantation use of levonorgestrel has not been associated with any harm as far as yet the Jason has not been established for ulipristal acetate.6

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References

Reply

We thank Dr Bhathena1 for his interest in our recent review article.2 The purpose of the review was to highlight the many different indications in gynaecological practice, in which progesterone receptor modulators (PRMs) may be applied and to focus on the potential health benefits of PRMs. PRMs have an endometrial antiproliferative effect in the presence of follicular phase estrogen levels, and this constitutes the basis of many of their potential advantages in the management of gynaecological conditions.

Currently, the only licensed indications for PRMs are postcoital preventation of pregnancy and ulipristal (UPA) for emergency contraception (EC) both relate to fertility control. Ulipristal has only recently received a licence based on good evidence of its effectiveness for EC even when taken up to 120 hours after intercourse.3,4 This Journal has previously published very informative commentaries and correspondence on this topic in emergency contraception.3,5 Like other PRMs, UPA is associated with suppression of ovulation and menstruation via an effect, which may not be easily explained by the effects of progestrone antagonism. Registration of UPA followed the publication of the UPA trial and meta-analysis in the Lancet.6 The authors of this paper pointed out that regarding the mechanism of action, an effect of UPA on the endometrium could not be ruled out although the effect on ovulation inhibition is potent. With respect to any potential harmful effect on pregnancy, it is reassuring to note that the rate of pregnancy in women treated with levonorgestrel and UPA for EC was not different.

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References

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 Mehigan 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 FSRH to take a progressive view of joint nurse and doctor training in shared fields. This Journal has previously published very informative commentaries and correspondence on this topic in emergency contraception.3,5

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References

Need for IUD fitters to have expertise in resuscitation

I was pleased to read the Personal View1 article 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 other Journal readers. It concerns the FCT’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.

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

None of us have ever can beanned 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 doctors! This is important to do so 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...