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 reproductive biology 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 perhaps surprising that 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, an as yet the license has not been established for ulipristal acetate.4–6

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References
4 Crockett HB, Braché V, Pavez M, Coleson L, Forloni F, et al. Pituitary-ovarian function 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 Mehigan and Khagendra Clay write therein.

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 (DSFRH) 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 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
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 Health Care Practitioners. They can then take the MFPH (Membership of Public Health) examination. They may be appointed as Consultants in Public Health and interestingly can act as advocates.
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 Immediate Medical Care) and the Royal College of Surgeons of Edinburgh is open to doctors, nurses and paramedics working in this field.
4 Society of Apothecaries
The RCPSG (DipChem 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 DMC (Diploma in the Medical Care of Abusers) is also open to nurses as well as doctors.
5 University diplomats
Most 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 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 have just read the Personal View1 on ‘Nurse training in SRH’ in the January 2010 issue of the Journal.

We have a related issue at the moment and would be interested to hear 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.

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

None of us have ever canned given or 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 by our named person to discuss this matter with.

None of our community clinics have resuscitation in mind as we do not have the facilities (e.g. ECG machine, oxygen etc). We are just trying to do what is right for our women. We do not need to have weekly IV drug administration, which would remove us all from clinic to theatre or similar to do so. Our resuscitation department is ensured 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
experience at IV administration. Perhaps we are unusual in that so many of our nurses do so many procedures. Do any readers know of anyone else who is struggling with the same issue? I have talked to one or two colleagues who were totally unaware of this guidance but I thought some of the Journal’s readers might be.

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5. Royal College of Nursing (RCN). Statement.

Letters to the editor

Nurse training and the need for IUD fitters to have expertise in resuscitation

I would like to put fingers to keyboard after reading the thoughtful Personal View by Shelley Mehigan and her colleagues1 along with the subsequent correspondence in the April 2010 issue of the Journal.

Nurse training in our specialty needs a nationally recognised and standardised educational pathway2 producing health care professionals who are ‘fit for purpose’. This training must be theoretically and practically robust, be based on sound evidence and the accreditation must not be overly expensive. Our services may still be ‘doctor-led’ in many parts of the UK, but clinics would come to a grinding halt if nurses are restricted in their practice and become ‘handmaidens’ once more. The letter written by Dr Barbara Hollingsworth3 clearly illustrates this point.

We have also had local community nurse-based clinics fitting intrauterine contraceptives in general practice premises suspended because ‘doctor cover’ by the general practitioners [who can administer intravenous (IV) drugs] has been withdrawn. Faculty guidance in Service Standards for Intracutaneous and Intradermal Contraception does not clearly state that a health care professional proficient in giving IV drugs is available on site but this is implied by having appropriate (0.6 mg) marketed IV drug available for IV Clinical Leads to check with their local Ambulance Trusts as many suggest that adrenaline is the only drug that needs to be available within community clinics.

I have recently asked over 70 health care professionals who fit intrauterine contraceptives about their use of atropine and no one has administered it. I have on one occasion in the last 22 years when a woman was very keen to keep an intrauterine device (IUD) in situ as she felt it was her only contraceptive option. On all other occasions when faced with vasovagal attacks or persistent bradycardias women have recovered by applying basic life support measures including the removal of the IUD device where necessary. Perhaps when both these documents4,5 are reviewed this issue will be clarified.

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5. Royal College of Nursing (RCN). Statement.

Safe sex during pregnancy

As a consultant in genitourinary medicine, I wish to comment on Box 1 of Stein et al’s1 “Is it safe to have sex?” in Susan Quilliam’s Consumer Correspondent article1 in the April issue of the Journal.

The second point made is that “if either partner has a sexually transmitted infection (STI), they should use protection...”. If one of a couple has an STI then it is generally recommended that for an untreatable infection a couple decide completely from having any penetrative sex until treatment of both partners is complete. Condoms do not provide 100% protection against any STI and any untreated infections in pregnancy can carry serious consequences.

I am uncertain why protected anal sex should be “avoided altogether”. If the couple exercises good hygiene practice is there any other concern about using a condom in pregnancy? I could not find anything in the article to explain this advice.

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Reference

Reply

First, I wish to thank Dr Young for reading my article1 so carefully and responding to it so thoughtfully in her letter.2 Dr Young is, of course, correct that if either partner in a couple has a sexually transmitted infection (STI) they should ideally not have sex at all until after treatment. However, in practice this advice is frequently ignored – particularly during pregnancy when partners want to reinforce their bond and reflect their closeness – so I was being pragmatic in advising against this practice.

Similarly, Dr Young is correct in saying that in ideal circumstances, anal sex is safe. But in the real-life situations I have been asked about, hygiene practices around anal sex are often far from perfect and so, again pragmatically, during pregnancy in particular I generally advise avoidance.

Finally, the aim of my article, and the substance of the main body of my text, was to promote sex in pregnancy and ask professionals to encourage it. I didn’t aim to give detailed information about risks – such information is covered fully in many other sources. Hence the guidance provided in the summary boxes gives headlines only rather than explaining in full the medical background.

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References

e-SRH e-Learning

As an Instructing Doctor for the Faculty of Sexual and Reproductive Health Care (FSRH), I have enjoyed completing this online training3 at www.e-lfh.org.uk. This is an excellent course and the animations, including the physiology of the