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 this? 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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Letters to the editor

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

I wrote to put fingers to keyboard after reading the thoughtful Personal View by Shelley Mehigan and her colleagues 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 pathway 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 Hollingworth 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suspended because ‘doctor cover’ by the general practitioners [who can administer intravenous (IV) drugs] has been withdrawn.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 Intrauterine 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 an 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 documents are reviewed this issue will be clarified.

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References
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 Dr Young’s article1 so carefully in 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 protection. Similarly, Dr Young is correct in saying that in ideal circumstances, anal sex is safe. But in the ‘real’ life situations I hear 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
The rationale for these changes is partly explained in an article by Trussell et al. Obesity is generally perceived to be an important risk factor in CHC users because of the high relative risk of venous thromboembolism (VTE). This well argues that, in terms of absolute or attributable risk, other cardiovascular risk factors are more strongly associated with VTE and mortality than obesity. Exceeding the risk of VTE in CHC users aged 45–49 years (UKMEC 2) is 175 per 100,000, which is greater than a VTE risk of 105 per 100,000 associated with CHC use and body mass index (BMI) >35 (UKMEC 3). The risks in terms of deaths in CHC users are even lower, with an absolute risk of 3.3 deaths per 100,000 in smokers aged <35 years (UKMEC 2) and a risk of 1.0 per 100,000 in women with BMI>35 (UKMEC 3).

With regard to the UKMEC 2009 section on multiple risk factors for cardiovascular disease, the text is unchanged from UKMEC 2005. The additional comments do appear to imply that the UKMEC definition of ‘older age’ is aged 40 years or above. Risk factors such as age are a continuum and there is not necessarily an exact cut-off. As Dr Lee acknowledges, UKMEC is only a guidance document, and it would be entirely appropriate for clinicians to apply their own clinical judgement.

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Reply
In her letter, Dr Lee raises a pertinent question regarding the new guidelines. The Medical Eligibility Criteria for Contraceptive Use (UKMEC 2009)2 categorises for body weight and combined hormonal contraception (CHC) use. The current Clinical Effectiveness Unit was not involved in updating UKMEC but we believe the body weight categories were made less restrictive to make them more consistent with the categories for other cardiovascular risk factors and CHC.

Menstrual cycle, convey concepts more dynamically than could ever be displayed on paper. Video consultations ... 58(6 Suppl.): 91S–97S.

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