menstrual cycle, convey concepts more dynamically than could ever be displayed on paper.

Video consultations demonstrate communication aspects in a powerful way. The introductory emphasis on the law, the client perspective and young people places contraception and sexual health within its practical context. Links to referenced sites are well chosen and accessible. The interactive self-assessment is challenging and – dare I say – fun, and I learned from some errors but I will not confess where.

I think e-SRH e-Learning is good preparation for the Practical Sessions of the FSRR Diploma, and with regular updating it will remain a valuable educational resource for us all in the future. Congratulations to all the team involved with this project.

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Queries about Faculty updated UKMEC

I would be grateful if the Faculty of Sexual and Reproductive Healthcare could explain why in the updated UK Medical Eligibility Criteria for Contraceptive Use (UKMEC 2009)1 the Category 4 for body mass index (BMI>40) has been removed? As a raised BMI is so closely associated with increased risk of venous thromboembolism, this does not seem logical.

Without the Category 4 status, I am concerned that increasing numbers of patients with a BMI>35 and indeed a BMI>40, will start, or continue to take, the combined pill, without any robust guidance to support this as a dangerous practice.

I am, however, pleased to see the Category 3/4 for 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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References

Implanon® failure in patients on antiretroviral medication: the importance of disclosure

We would like to draw other practitioners’ attention to a patient recently referred to our clinic, namely Implanon® failure in two women on antiretroviral (ARV) medication who failed to mention Implanon use to their HIV physicians. Our aim is to highlight the need for disclosure of HIV diagnosis to physicians offering contraceptive choices and Implanon use to the HIV physicians.

A 33-year-old woman, para 3, attended in May 2007, requesting termination of pregnancy. She had an Implanon since July 2004 and was amenorrhoeic until February 2007. She was counselled on Sustiva® (efavirenz 600 mg tab) and Truvada® (emtricitabine 200 mg and tenofovir disoproxil 245 mg) in January 2007 as her HIV viral load was rising. She was not asked and did not volunteer Implanon use. Concerns for the adverse effect of the ARVs on the fetus had prompted the termination request. After a normal dating ultrasound scan her decision to terminate became apparent. She was counselled to continue the pregnancy after a 5-week scan and delivered a male baby weighing 3520 g at term.

A 35-year-old woman, para 1, conceived with an Implanon when commenced on efavirenz and lopinavir. She did not mention Implanon use to the HIV physician, and the contraceptive clinic had no record of her HIV status. She did not appreciate that Implanon was a drug that might interact with ARVs. She continued with the Implanon and did not realise she was pregnant until 19 weeks. After counselling she opted for a mid-trimester termination.

The concentration of contraceptive hormones may change by concomitant drug use and vice versa. It is good practice to enquire about current and previous drug use (especially liver enzyme-inducers) when offering hormonal contraception. We believe that some drugs might reduce hormonal contraceptive effectiveness. With the exception of the progestogen-only injectable or the levonorgestrel intrauterine system, the contraceptive efficacy of hormonal methods is reduced by liver enzyme inducers.1

Some ARVs, such as protease inhibitors (amprenavir, atazanavir), saquinavir, ritonavir) and non-nucleoside reverse transcriptase inhibitors (efavirenz, nevirapine), are metabolised by the CYP3A4 liver enzyme system and can affect contraceptive efficacy.1

Each Implanon contains 68 mg etonogestrel (ENG). The subdermal delivery method makes it 100% bioavailable. Serum ENG concentrations increase rapidly within 8 hours of insertion and peak after 4 days.2 The release rate is 60–70 µg/day in weeks 5–6 post-insertion, and decreases to 35–45 µg/day at the end of the first year, to 30–40 µg/day at the end of the second year, and then falls to 25–30 µg/day at the end of the third year.3 These low concentrations are sufficient to inhibit ovulation for 3 years.3

The advice for using an etonogestrel-only implant for women on long-term liver enzyme-inducing drugs is to continue using it together with additional contraceptive protection (such as condoms) and for 4 weeks after the drugs are stopped.1

These cases highlight the unforeseen consequences of non-disclosure of HIV for both patients and physicians. One of the dilemmas facing physicians is whether to disclose the HIV diagnosis to general practitioners (GPs). Arguments have been advanced for specialists because of confidentiality and notifying the GP against patients’ wishes in the interest of normal medical practice, the patients’ and health personnel best interests, and the interests of society in general. Gillon4 examines each argument and concludes that none is sufficient to justify violating patient physician confidentiality in most cases.5

Early contraceptive failure of Implanon in a woman on antiretroviral medication has been described.5 The patient in the case report had an ectopic pregnancy.

The majority of HIV-positive women are of reproductive age. Contraceptive options must take into account the risk of an unintended pregnancy, vertical transmission, and horizontal transmission, and a non-disclosed patient might not achieve all these goals, a combined contraceptive (barrier method plus another method) is the ‘gold standard’. Some practitioners will argue that the ‘Double DUTCH’ advice should be given to all patients and not just HIV-positive women.

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3 Croxatto HB, Mäkäräinen L. The pharmacodynamics and pharmacokinetics of Implanon. An overview of the data. Contraception 1998; 58 (6 Suppl.): S1S–S75.
Letters to the editor

Contraceptive failure and the progestogen-only pill

The case report by Chandler and Nash 1 in this issue of the Journal is interesting and highlights the need for trials of hormonal contraceptive use to include obese women.

The authors acknowledge that despite an apparent association between contraceptive failure and higher body weight in studies of a Norplant® prototype and a levonorgestrel-releasing vaginal ring, there is insufficient evidence to demonstrate reduced efficacy in heavier women using the progestogen-only pill (POP). Current guidance from the Faculty of Sexual and Reproductive Healthcare (FSRH) 2 advises one progestogen-only pill (POP) per day irrespective of body weight. This recommendation is based on the evidence available at the time of publication and the consensus of the guideline development group.

The recent review of obesity and oral contraceptive pill use (OCP) 3 lends further support to FSRH guidance. The authors conclude that “they found no convincing evidence that very heavy or obese women have a higher risk of oral contraceptive pill failure and progestogen-only failure during perfect use than thinner women, even with the lowest doses formulations”. Trussell and colleagues mention the need for reliably measuring adherence and they speculate that OCPs may be less forgiving of imperfect use among heavier women.

Given that long-acting reversible methods of contraception (LARC) are known to be highly effective and less dependent on adherence than OCPs, LARC methods should be offered to all women, particularly following OCP failure.

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References

Lost IUD penetrating bladder wall

The incidence of uterine perforation following intrauterine device (IUD) insertion is reported to be approximately 1 in 1000 insertions. 1 Misplaced IUDs can be diagnosed simply with speculum examination. Missing threads is the usual sign and may be due to unrecognised expulsion, enlarged uterus due to pregnancy, the IUD threads becoming occluded or the woman not reporting on time for a follow-up visit. Accompanying pelvic pain is also another sign of possible problems. Our patient had pelvic pain for 4 months following IUD insertion and did not attend for a check-up. Because she attributed this pelvic pain to the insertion procedure, the opportunity for an early diagnosis was lost.

Conversely, the patient sought medical help in order to discover whether the device had dropped out and this was associated with decreased pelvic pain following this painful period. Unfortunately, medical staff concurred with the patient’s stated belief that the IUD had dropped out, and so did not perform further investigations to confirm or refute this belief. Interestingly the patient experienced no problems afterwards, until the diagnosis of a misplaced IUD nearly 15 years later.

We believe that this is the first case of bladder perforation reported in the scientific literature. It is a matter of debate in this case as to whether the uterus was iatrogenically perforated or whether the IUD moved through the uterine wall during pregnancy. This case also demonstrates an uncommon localisation of an IUD and the close relationship between pelvic pain and IUD misplacement. This case also emphasises the need for regular check-ups following IUD insertion and the need to be suspicious of possible locations other than the uterus. Most importantly, an accurate diagnosis may facilitate the use of endoscopic techniques and result in minimally invasive treatment.

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