LETTERS

Anti-D guidelines
Madam,

We read with interest the letter on ‘GP use of anti-D’ published in April 2000 and would like to draw attention to the recent changes in the guidelines for the administration of anti-D in early pregnancy as recommended by the British Transfusion Society and the Royal College of Obstetricians and Gynaecologists.

The following points are relevant:

1. Anti-D must be given to all RhD negative women having therapeutic termination of pregnancy, whether by surgical or medical methods, regardless of gestational age, unless they are known from blood tests alone to already have anti-D.

2. Anti-D must not be given to all non-immunised RhD negative women who have an ectopic pregnancy, irrespective of gestational age.

3. Anti-D must be given to all non-immunised RhD negative women who have a spontaneous complete or incomplete abortion after 12 weeks of pregnancy.

4. Anti-D should be given when there has been instrumented intervention to evacuate the uterus. Spontaneous complete miscarriage before 12 weeks does not require any anti-D, as significant fetomaternal haemorrhage does not occur.

5. Routine administration of anti-D is not recommended in threatened miscarriage with viable pregnancy. However, it may be prudent to administer anti-D where bleeding is heavy or repeated, or where there is associated abdominal pain specifically as gestation approaches 12 weeks. When bleeding continues intermittently after 12 weeks gestation, anti-D should be given at 6-weekly intervals. The gestational age should be confirmed by ultrasound.

Full guidelines are available from the College or can be downloaded from the website: http://www.rcog.org.uk/guidelines/anti.html.

These guidelines represent evidence-based practice. Based on these guidelines, women in the community or in hospital who have a spontaneous miscarriage without therapeutic intervention, or threatened miscarriage prior to 12 weeks, do not need anti-D. Therefore the reported 7-11% of the RhD negative women who were cared for in the hospital had received adequate care.

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References

FP provision in GUM clinics
Madam,

In their article,1 Bardsey et al discussed contraception services provided by family planning clinics and GPs in London. They failed, however, to consider the role of the genitourinary medicine (GUM) departments. A survey shows that only 7 of 45 GUM and 53 of 89 family planning services, offered by local GUM clinics, was undertaken as part of North and South Thames Regional GUM audit in August 1996. A survey of 31 GUM and North Thames and 33 units in South Thames was conducted. Thirty-seven units returned completed questionnaires giving a 58% response rate. Over 70% of responding units (n = 27) provided contraception with one third (n = 12) offering specific family planning services. One quarter of responding units (n = 9) had a designated family planning doctor with 30% (n = 19) employing a family planning nurse. Both the Yuzpe (31 units; 84%) and the progesterogen-only (12 units; 32%) hormonal contraception methods were offered. In addition, eight units (22%) offered emergency intrauterine device contraception. Despite variations, including participation rate and self-reporting bias, these results suggest that family planning and emergency contraception provision within GUM is considerable. There are a number of benefits of providing such a service. Walk-in clinics offer convenient access to specialist advice without appointment, thereby assisting younger clients. Screening for sexually transmitted infections, partner notification and health promotion can be provided within an integrated service.

Indirect evidence from KC 60 statistical returns shows that increasing numbers of women are accessing GUM departments, with a 19% increase in family planning provision between 1997 and 1998.2 Furthermore, all specialist registrars in GUM are required to obtain the Diploma of the Faculty of Family Planning (DFFP) as an essential training requirement. The advantages of providing family planning/ contraception in association with GUM services have been recognised3,4 and form part of the Sexual Health Strategy currently under discussion.

Acknowledgement
We should like to acknowledge all those who contributed to the Regional GUM Audit process in the North and South Thames regions.

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The Nova T series IUDs
Madam,

Following the review article on IUDs in the January 2000 edition of the BJFP,1 the question arises as to whether family planning services should abandon the Nova T200 for the Nova T380, and whether GP practices should advise their local GPs and PCGs to do the same. I believe that this needs some consideration, as the Nova T380 is over twice the price of the older version and is not reimbursable on the NHS for GPs. The chief use of the Nova T series is in women with a narrow cervical canal, as the inserter tube is slimmer than the Gyne T380 or the Gyne T380 Multidose. Many of these will be young nulliparae needing a post-coital IUD, which will be removed at 3 months after failure rate of post-coital IUDs is no higher than 0.1 %. Is there any evidence that the Nova T200 is less effective than the 380 in this situation?2

The published evidence on the superior effectiveness of the Nova T380 only extends to 2 years of follow-up on 259 women.3 Further work is in progress through the UK family planning network. Should we wait for this evidence before making a decision for our services at a time when budgets are under pressure and clinics all over the UK are threatened with closure?

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References

FEES FOR DFFP PRACTICAL TRAINING SESSIONS

Madam,

For several years now the training clinics in Devon and Cornwall have charged £20.00 per session for the practical sessions for the DFFP. Up until now there has been no problem with this. However, this year the Plymouth VTS training scheme has started to complain about having to pay for their practical training sessions in our area. Apparently they are not able to claim for these fees from the postgraduate training budget.

I would very much like to know if other training centres for the practical training sessions and, if so, how much.

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Training fees and DFFP: Reply

Madam,

Support for training is available and is administered in different ways throughout the UK. The training budget allocation supports all vocational education training. This budget has been devolved and is administered regionally by postgraduate deans. It is a cash limited budget and will be used locally to support a variety of activities within the training budget. Support for trainees, half day release for trainees, travel and subsistence and support for the trainers.

Most trusts have a training component. GP vocational trainers should get the fees for the theoretical course and practical training reimbursed through the vocalional training budget. The training fees for trainees gain part of the practical experience within a general practice setting. The DFFP logbook should facilitate this where it is locally relevant to the training process. Sessions attended in general practice settings are usually charged for (unless there is a reciprocal exchange of trainees with another department which has been previously negotiated) and should be reimbursable. The basis for funding for many community services is for delivery of clinical services and does not recognise a training component. In order to fund trainees and training commitments, most services charge for practical training sessions. This is in the order of £20-25, which is roughly the additional salary cost to upgrade a CMO session to that of an instructing doctor.

In hospital settings there is often a cash limited sum allocated to each SHO for training which they can prioritise for DFFP. This cash limit is in excess of the sum normally charged for complete DFFP.

At a local level you need to enter into negotiation with the gatekeeper of the money - the postgraduate dean - and enlist the help of your regional advisor.

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