LETTERS

What's in a name?

Madam,

The new name for the Journal is entirely appropriate, but please don't omit 'Family Planning' from the title. Women in the developed world are the role models for the developing world. They look to us for guidance. In the developing world, 'Family Planning' means just that. It is a respectable phrase which is accepted and recognised in many languages. We owe it to them not to alter the name.

Who would benefit from a change? Not our client groups - I don't think the phrase 'sexual health' will mean anything to younger people, and the term is very likely to alienate older women.

I have a feeling that the professionals are the only ones who would benefit from our use of a more scientific name, since it would make them feel more acceptable to their colleagues as 'proper' and 'scientific' doctors.

When the original NAFPD was formed, the debate ranged long and hard over the name of the association. Fortunately, we did not adopt 'Organisation for Reproductive, Gynaecological And Sexual Medicine' (ORGASM).

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Lesson of the week – Norplant failure

Madam,

A 32-year-old woman (weight 60 kgs) presented with pelvic pain and vaginal bleeding. Four weeks earlier she had had a large loop excision diathermy of the transformation zone of the cervix (LLEDTZ) for severe dyskaryosis. A Norplant contraceptive had been inserted 3 years earlier and she had had irregular menstruation.

An initial diagnosis of pelvic infection related to the cervical treatment was made, but surprisingly a pregnancy test was positive. An ultrasound scan revealed a gestational sac outside the uterus and a laparoscopic salpingectomy was performed for a tubal ectopic pregnancy. She made an excellent recovery from the procedure. Her faith in the Norplant is somewhat shaken, however, and the couple are planning to use condoms for extra contraception protection whilst her husband arranges a vasectomy.

This is the first pregnancy we have seen locally with experience of over 330 Norplant insertions. The reported Pearl index for Norplant is 0.2/100 woman years. The timing of this pregnancy suggests that a reduction in the protective cervical mucus caused by the LLEDTZ allowed pregnancy to occur.

Unlike Norplant, Implanon inhibits ovulation and effects on cervical mucus are not a major consideration. At present, however, we still have many women using Norplant for contraception. Should we be advising them and users of the progestogen-only pill that additional barrier conception should be used during a cycle when cervical treatment is planned? We look forward to hearing other readers’ thoughts on this issue.

Margaret Tasker, FRCOG, MFFP, Consultant Obstetrician and Gynaecologist; Karl Hattotuwa, MRCPG, MFFP, Formerly Senior Specialist Registrar; Bolton Hospitals NHS Trust, Royal Bolton Hospital, Minerva Road, Farnworth, Bolton, B14 0JR.

The typical histological changes reported with the levonorgestrel-releasing IUS are thinning of the endometrium with glandular atrophy and decidualisation of the stroma. The case we have described has led us to think that it is important to collect and report data on the status of strings or ‘missing’ threads of levonorgestrel-IUS.

Nuriye Ortyayi, MD, Obstetrician and Gynaecologist; Lale Say, MD, Woman and Child Health Training and research Unit, Medical School of Istanbul, Istanbul, Turkey.

Fibrosis attached to the tail of a levonorgestrel intra-uterine system

Madam,

Intra-uterine devices (IUDs) are the most popular modern contraceptive in Turkey, used by nearly 20% of the women of reproductive age. At the clinic of the Woman and Child Health Training and Research Unit of the Medical School of Istanbul we insert nearly 1000 IUDs each year. We are also a referral centre for problems and complications that arise with IUDs fitted by other family clinics on the European side of Istanbul - a region with nearly five million inhabitants. Lost IUD threads are therefore a common problem referred to our clinic. We usually remove all IUDs without visible threads, using either alligator forceps or a hooked IUD remover. This is performed as an outpatient procedure and without much difficulty.

On November 25th 1999, a 25-year-old multiparous woman was referred who had a levonorgestrel intra-uterine system (IUS) inserted 17 months previously; the threads of the device could not be visualised. An ultrasound scan confirmed the diagnosis and it was confirmed that the IUS was still present in the uterine cavity. It was decided to leave the device in place and to follow the client according to our routine schedule. Twelve months later the device was removed at her request. The removal was achieved easily using alligator forceps, although a slight resistance could be felt.

When the IUS was removed, a blue-grayish, shiny mass 1.5 cm in diameter was attached to its lower end (Figure 1). This was a finding we have never observed before with copper bearing devices. The IUS, with its attached mass, was sent to pathology and reported as: ‘foreign body reaction: fibrosis which contains dominantly collagen fibres and to a lesser extent capillary vessels’. The mass was decidualised and contained connective tissue and foreign body giant cells and inflammatiory cell infiltrations.

Figure 1

This small study suggests that 66% of women taking HRT would not be prepared to stop treatment for more than 1 month before mammography, while 31% would be willing to stop for 3 months or longer. At the present time, it is uncertain exactly how long it would take to reverse the mammographic changes that are induced by HRT (10-30 days). The regression of mammographic density before we attempt to persuade large numbers of women to temporarily stop for 3 months or longer. At the present time, it is uncertain exactly how long it would take to reverse the mammographic changes that are induced by HRT (10-30 days). The regression of mammographic density before we attempt to persuade large numbers of women to temporarily stop HRT prior to mammographic screening.

Alex Stirling, MBBS, Senior House Officer; Ailsa Gebbie, MB ChB, MRCPG, MFFP, Consultant Gynaecologist, Anna Glaser, MD, FRCOG, MFFP, Director and Consultant Gynaecologist, Family Planning and Well Woman Services, London Primary Care NHS Trust, 18 Dean Terrace, Edinburgh EH4 1NL, UK.

References

1 Hacettepe Institute of Population Studies, Macro Int. Demographic Health Survey, Turkey, 1998.

Will women stop HRT prior to mammographic screening?

Madam,

Concerns exist that hormone replacement therapy (HRT) reduces the sensitivity of mammographic screening. This therefore raises the issue of whether HRT should be discontinued prior to mammography in order to improve the sensitivity and specificity of the screening procedure. The issue is twofold: first, for how long would women need to stop taking HRT and, second, would they be willing to do so?

In large community menopause clinic, 100 women aged 50-65 years (who were already taking HRT for relief of menopausal symptoms) were given a questionnaire asking how long they would be prepared to stop HRT for if they were told that it would make interpretation of their mammograms easier. The results are shown below (Table 1).

<table>
<thead>
<tr>
<th>Duration of time</th>
<th>Number of Women willing to stop HRT</th>
</tr>
</thead>
<tbody>
<tr>
<td>None</td>
<td>13</td>
</tr>
<tr>
<td>1 week</td>
<td>14</td>
</tr>
<tr>
<td>1 month</td>
<td>39</td>
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<tr>
<td>3 months</td>
<td>19</td>
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<td>6 months</td>
<td>5</td>
</tr>
<tr>
<td>9 months</td>
<td>1</td>
</tr>
<tr>
<td>1 year</td>
<td>6</td>
</tr>
<tr>
<td>Don’t know</td>
<td>3</td>
</tr>
</tbody>
</table>

Table 1. Results of questionnaire


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Experiences of termination of pregnancy in a stand-alone clinic
Madam,

We read the article by Boorer and Murty with great interest, and believe that it highlights a major discrepancy in the provision of NHS care. We believe that termination of pregnancy (TOP) under local anaesthetic should be available to all women requesting termination, as part of a wider choice of methods within a NHS setting.

We are grateful to Boorer and Murty for their account of safety, simplicity and effectiveness of local anaesthetic Manual Vacuum Aspiration (MVA) in first trimester TOP. They were amongst the pioneers of the introduction of this ground-breaking technique into the UK, and in the provision of services outside of hospital settings. After performing over 2000 MVA procedures in stand-alone charitable clinics, we have now introduced the technique into our NHS hospital setting. We therefore feel well positioned to add to the positive observations of Boorer and Murty.

The key to a ‘woman-centred’ TOP is ‘choice’ in all aspects of provision. Part of this ‘choice’ is the tailoring of methods to individuals. We believe that all women undergoing TOP should have a choice of all suitable available methods. When a woman has made her choice, the technique that she has chosen can then be developed to meet her individual needs. For example, MVA can be made even more acceptable by offering women a choice of analgesia. The British Pregnancy Advisory Service (BPAS) studied their first 500 women available within an NHS setting.

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References

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Re: Stage la endometrial carcinoma diagnosed on removal of an IUD

It was interesting to read the above case report by De Kay in the April 2001 issue of the Journal. However, the coincidental findings of an endometrial carcinoma at the time of removal of an IUD is not an entirely uncommon event. I accept that there is no overall increase in the incidence of the disease with IUD use. However, the issue as to whether there is an association with long-term use without a change of device has not been addressed. The case reported had a 20-year history of use without change.

Similarly my case report and brief review by Ojutiku and Morcos notes the development of a squamous cell carcinoma of the endometrium following 25 years of IUD use without change. Despite the possible protective role noted by Parazzini et al., it is difficult to see how a chronic inflammatory response would not eventually lead to some degree of cytological atypia. I am also yet to see a plausible mechanism for protection. In addition, the relative hypo-oestrogenic environment of the menopause may also play a role in its development. I feel strongly that postmenopausal women with a history of long-term IUD use without change should, where asymptomatic, be investigated with a high level of suspicion.
What's in a name?

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