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 NAPFF 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.

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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 ultrasonography was performed and it was confirmed that the IUS was in a fundal position within the 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 formations can be observed. Granulation tissue of young elements of connective tissue, foreign body giant cells and inflammatory cell infiltrations’.

Figure 1

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.

Nuryie Ortyal, MD, Obstetrician and Gynaecologist; Lalay Say, MD, Woman and Child Health Training and research Unit, Medical School of Istanbul, Istanbul, Turkey.

References

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 whether HRT should be discontinued prior to mammographic screening. 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 a large community menopause clinic, 100 women aged 50-65 years (who were already taking HRT for relief of menstrual 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 1 Results of questionnaire

<table>
<thead>
<tr>
<th>Duration of time willing to stop HRT</th>
<th>Number of Women N = 100</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>
</tr>
<tr>
<td>3 months</td>
<td>19</td>
</tr>
<tr>
<td>6 months</td>
<td>5</td>
</tr>
<tr>
<td>9 months</td>
<td>6</td>
</tr>
<tr>
<td>1 year</td>
<td>3</td>
</tr>
<tr>
<td>Don’t know</td>
<td>3</td>
</tr>
</tbody>
</table>

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 hormone-induced mammographic changes potentially improves mammographic specificity and thus helps to avoid unnecessary biopsy.

There is an urgent need for a large prospective study looking into the effect of stopping HRT on mammographic density before we attempt to persuade large numbers of women to temporarily discontinue HRT prior to breast screening.

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References
Experiences of termination of pregnancy in a stand-alone clinic

Madam,

We read the article by Boorer and Murty1 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 practice. 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 of analgesia. The British Pregnancy Advisory Service (BPAS) routinely offer Entonox to their MVA patients. The British Pregnancy Advisory Service (BPAS) have now introduced the technique into our NHS hospital practice. We therefore feel well positioned to add to the positive observations of Boorer and Murty.

The women requesting the technique is. All women undergoing TOP who scored median values for pain of three. When asked if their experience of MVA were compared with patients undergoing medical termination who scored median values for pain of six. When asked if their experience of MVA were better or worse than expected (visual analogue scale, 1 = better than expecting, 10 = worse than expecting) the median score was three.

We find that each procedure is as individual as the woman requesting the technique is. All women should have an informed choice of method of TOP. This choice should be easily available within an NHS setting.

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References
What's in a name?

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