Intrauterine device expulsions

In an attempt to raise awareness of an apparent increase in intrauterine device (IUD) expulsions noted since we started using the TT380 Slimline® in Autumn 2005, we write to our readers.

As clinical policy we changed our preferred first-choice copper IUD to TT380 Slimline, mainly because of its 10-year licence compared to 8 years with the T-Safe® Cu380A. In early 2006 we noticed that a number of women were returning soon after insertion with either full or partial expulsion.

Two experienced doctors fit the majority of IUDs, either personally or as part of supervision for the FFPRHC Letter of Competence in Intrauterine Techniques (LoC IUT). We reviewed our IUD data from 1 January 2005 to 1 March 2006, choosing the dates to give roughly equivalent numbers of T-Safe Cu380A and TT380 Slimline insertions. We excluded insertions done by any other clinicians.

From Table 1 we can see that we were able to identify those women who had not returned for follow-up and those who did not continue with the IUD. Only 3% of the women remaining in the first 3 months after insertion were included, although later expulsions also appear to be increased. We also noted an increase in women asking to have their IUD removed within the first 3 months. The results are shown in Table 1.

Table 1 Summary of IUD fitting data

<table>
<thead>
<tr>
<th>Device</th>
<th>Total</th>
<th>No data</th>
<th>No follow</th>
<th>Expelled</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td>(fillings)</td>
<td>(expulsions)</td>
</tr>
<tr>
<td>T-Safe Cu380A</td>
<td>115</td>
<td>3</td>
<td>24</td>
<td>0</td>
</tr>
<tr>
<td>TT380 Slimline</td>
<td>104</td>
<td>5</td>
<td>19</td>
<td>4</td>
</tr>
<tr>
<td>Nova-T® 380</td>
<td>15</td>
<td>1</td>
<td>2</td>
<td>0</td>
</tr>
<tr>
<td>Gynaec-Tabs®</td>
<td>12</td>
<td>0</td>
<td>3</td>
<td>0</td>
</tr>
<tr>
<td>Mierna® (IUS)</td>
<td>196</td>
<td>2</td>
<td>19</td>
<td>2 (1)</td>
</tr>
</tbody>
</table>

N.B. Data from the first 9 months of TT380 Slimline are not included in this table.

Acknowledgement

The authors are grateful to the Medical Research Council for financial support through the course of the Oxford-FPA study.

References


Increase in IUD expulsions

Ortho Gynae T380®. The TT380 Slimline takes longer to open fully post-fitting in vitro. We are careful to fit the device immediately after loading so the device is compressed within the tube for as little time as possible.

We value feedback from colleagues on their experience of using the TT380 Slimline.

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Liquid-based cytology

We very much welcome Dr Williams’ commentary1 in the July 2006 issue of the Journal on any advantage that liquid-based cytology (LBC) may offer and his criticism of the systematic review by Davey et al.2 It is surprising that the favourable results of the large five pilots in London and England, Scotland and Wales were not included. Two recent publications from this country echo the LBC pilots as regards significant reductions in inadequate rates with LBC.3,4

Our positive experience at PathLinks with LBC are in line with these publications. PathLinks is a pathology network which serves Greater Lincolnshire and Goole; the catchment population is approximately one million. The laboratory processes around 65 000 cervical cytology samples annually and the liquid-based service implementation of LBC began in June 2005, with one of the six PCTs converting every 6 weeks coinciding with training completion of a pathologist, a checker and three cytoscreeners. A total of 30 staff converted and provide the present service. Turnaround time just prior to conversion was 6 weeks. Presently this is 2 weeks, with around 90% of results being reported within a week. The inadequate rates were as follows: pre-conversion (April 2004–March 2005) 7.75%, during conversion (April 2005–March 2006) 4.9% and post-conversion 0.8%. The high-grade rates during these periods were 0.95% and 1.1%, respectively, suggesting concordance with the expectation of increased sensitivity of LBC. Our cytoscreeners have found the LBC slides to be clean and easier to compare to conventional smears. Detection of endometrial cells is more frequent although this offers a diagnostic advantage. Cytoscreeners were reluctant to return to interpreting conventional smears.

Whether the LBC can be made more cytoscreener-friendly is being explored by the NHS Health Technology Assessment Programme through the MAVARIC trial. Automated technology may make identification of abnormal cells easier. The computerised software will direct the cytoscreeners to probe some 20 locations on a slide rather than painstakingly scanning the whole slide. Furthermore, one of the machines (FocalPoint®) can sort the abnormal slides into quintiles. Up to 25% of the samples are likely to be classified as ‘no further review’ meaning that manual reading is not required. The MAVARIC trial set up in August 2005 compares two automated cervical screening technologies - manual screening. Cytology samples are randomly allocated to reading by manual screening alone or by one of the two automated technologies which is set up by manual screening. The trial is expected to end in 2009 and the published results are due in 2011. Further uses of LBC are being actively researched. LBC lends itself to the hybrid capture technique for the human papillomavirus test5 and for chlamydia screening.6

LETTERS

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