Chlamydia testing in the UK
The statement in the commentary article by Skidmore et al.1 that “in the UK, the Department of Health has provided funding for all National Health Service (NHS) laboratories to adopt commercial amplification tests”, for the detection of Chlamydia trachomatis, seems to be based on treating the terms England and UK as synonymous. While that might be an understandable mistake, it is still a mistake. In 2003, the Department of Health in England provided £8 000 000 to support laboratory services to change from the inaccurate and cheap enzyme-linked immunosassay tests (ELISAs) for C. trachomatis to the accurate but expensive nucleic acid amplification tests (NAATs).2 Four years later, the Chief Medical Officer (CMO) in Wales has taken a similar view that testing platforms for the detection of genital C. trachomatis other than NAATs are suboptimal. Underestimating the accuracy of the CMO estimates that it will only cost £150 000 to extend the use of NAATs across the whole of Wales and states that “service commissioners and providers would be highly vulnerable to criticism if what is now the ‘gold standard’ was not used”.1 I do not think any that funding has been provided to the laboratories in Wales.3
Here in Mid Wales we are still using an ELISA to detect, as the CMO estimates, 70% of female and 54% of male genital C. trachomatis infection4 and, as I write this letter, we have but 7 weeks to comply with the CMO’s expectation that all individuals tested for chlamydia infection in Wales will be offered the NAAT by 1 December 2007.3

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References

Implanon® failure and antiretroviral therapy
We would like to add Matiluko et al1 to the October 2007 issue of the Journal with interest. Efavirenz, a non-nucleoside reverse transcriptase inhibitor (NNRTI), is known to have complex interactions with cytochrome P450 enzymes, being both an inhibitor and an inducer of this system. Characteristically it has been the protease inhibitor (PI) class of antiretroviral therapy (ART) that has been associated with contraceptive failures. Nonetheless, both commercially available NNRTIs (efavirenz and nevirapine) are associated with reduced contraceptive efficacy of Implanon® in an HIV-seropositive patient on triple antiretroviral therapy with zidovudine, lamivudine and efavirenz. J Fam Plann Reprod Health Care 2007; 33: 277–278.

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References

Difficult IUD insertions
After approximately 25 years’ experience of fitting intrauterine devices (IUDs) in general practice, I have of late found myself pondering why slowly the process seems to become increasingly difficult. Rather than becoming easier the more experience I gain, IUD fits seem to become more problematic. Surely not what one would expect?
And then the penny dropped. Back in the 1980s, the standard IUD was the那天 3s with two or three vaginal deliveries behind her who had lost all her informations about gynaecological procedures years before. Today’s IUD patient may have had previous therapy by Caesarean section, or be nulliparous, in her early 40s and requesting a Mirena® for menstrual problems; neither individual will be the easiest to fit with an IUD and neither will be well prepared for the indignity and discomfort that inevitably accompanies the procedure. Would other experienced practitioners concur with this, or am I just making excuses?
Because if I’m not making excuses, we need better means of handling the pain of an IUD insertion, dilators, sounds and progestogen devices that are suitable for nullips, tenaculæ that cause minimal pain, and so on. And concern for the trainees who have to learn in this environment. All sensible comments are very welcome.

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Training for the LoCo IUT
As a practising instructing doctor, I disagree with the arguments put forward by Dr Devondai in her letter in the October 2007 issue of this journal2 for considering altering the criteria for this qualification.
Within our practice we actively promote the use of intrauterine devices (IUDs) and the intrauterine system (IUS) as long-acting reversible contraceptive (LARC) methods in suitable women. All women requesting an intrauterine method are seen at an initial counselling and assessment session to discuss their contraceptive needs and they are informed about all their long-term options. We find that this allows women to be informed users and improves compliance with their chosen method.
As a result, 2005–2006, I fitted 162 copper IUDs, which were mainly the ‘gold standard’ TCu380A (T-Safe380A®) and 57 Mirena® devices. Last year (i.e. in 2006–2007) this changed to 181 IUS and 43 Mirena® devices. One patient had to change to Mirena due to heavy periods but the rest have reported no problems with pain or bleeding. Conversely, one Mirena had to be removed within a week of insertion, and another like the idea of having a hormonal coil. She had originally been counselled by her own general practitioner (GP).