I agree with Dr Devonald’s comment that most GPs will only fit Mirenas. In my opinion, this is contrary to patient choice and good practice. In the area where I work, women are directly asking for a non-hormonal LARC, or after discussions find irregular bleeding patterns or amenorrhea with Mirena unacceptable. Also, an IUD may be needed for emergency contraception purposes. Therefore, I believe that the copper IUD is a very useful method in good hands and there is enough evidence around to prove this.

In the light of the above comments, I would therefore argue that there is no need to consider changing the criteria for the Letter of Competence in Intrauterine Techniques (LoC IUT) training. However, more importantly, our efforts should focus on improving timely access to high-quality training for LoC IUT and Letter of Competence in Subdermal Contraceptive Implant Techniques (LoC SDI). I have been made aware by current trainees that there are some real issues with arranging suitable practical training sessions. There can be a wait for up to a year in some areas for training. Some GP registrars are no longer planning to undertake LoCs as they feel that there is a lot to do during their training year and they cannot spare the time, particularly if the training clinic is located miles away. Some of the trainees are also unable to obtain study leave or find locums if they wish to undertake LoCs. This is more worrying for the specialty as a whole and obviously limits patients’ choice in the long term. I wonder, therefore, whether there is any possibility of including DFSRH (formerly DFFP) and LoC training as it relates to IUDs/implants as a core skill during the obstetrics and gynaecology placement?

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**Missed opportunities in discussing LARC**

We conducted a study on the feasibility of self-completed history questionnaires in a central London community contraceptive clinic in October 2006. Participants were established users of combined hormonal contraception (CHC, which includes the pill and the patch) requesting repeat supplies. Along with questions on personal and family history to identify risk factors, we included a question: “Would you like to discuss other methods of contraception such as long-acting methods which you do not have to remember to take each day?” Twenty-one percent (68/328) of women replied “Yes” to this question. This is an important finding, considering the fact that these women were already well established on their CHC.

Given this response, we suggest that when a woman comes for repeat supplies of her CHC, it should be taken as an opportunity to discuss long-acting reversible contraception (LARC) methods. Choice of contraception is essential to meet diverse user needs, and preferences may change with the user’s stage in life. Only by offering choice will the maximum number of women be protected and will the uptake of LARC increase. If health professionals make assumptions that a woman’s current method of contraception is the best and most acceptable to her, they could be missing opportunities for discussing other methods.

The National Institute for Health and Clinical Excellence (NICE) guidance recommends that all women requiring contraception should be given information about, and offered a choice of, all methods, including LARC. Little is known about the extent to which women requesting contraception are actually offered these methods. In general practice, the availability of LARC methods is often limited, which is also likely to affect uptake.

LARC offers definite cost benefits to health services, with all methods being more cost-effective than the combined oral contraceptive pill even at 1 year of use. In addition, these methods offer non-contraceptive health benefits, such as the levonorgestrel intrauterine system providing treatment for menorrhagia.

Therefore, I believe that there is no need to consider changing the criteria for the Letter of Competence in Intrauterine Techniques (LoC IUT) training. However, more importantly, our efforts should focus on improving timely access to high-quality training for LoC IUT and Letter of Competence in Subdermal Contraceptive Implant Techniques (LoC SDI). I have been made aware by current trainees that there are some real issues with arranging suitable practical training sessions. There can be a wait for up to a year in some areas for training. Some GP registrars are no longer planning to undertake LoCs as they feel that there is a lot to do during their training year and they cannot spare the time, particularly if the training clinic is located miles away. Some of the trainees are also unable to obtain study leave or find locums if they wish to undertake LoCs. This is more worrying for the specialty as a whole and obviously limits patients’ choice in the long term. I wonder, therefore, whether there is any possibility of including DFSRH (formerly DFFP) and LoC training as it relates to obstetrics and gynaecology placement?

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