acute Trust for removal, where they still re-
sterilise instruments.

Do the authors know of a source for the
correct single-use instruments, or can a
manufacturer be encouraged to develop the
appropriate items?1

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Reference
1 Mansour D, Walling M, Glenn D, Egarter C, Grasslin
O. Removal of non-palpable etonogestrel implants. J Fam Plann Reprod Health Care
2008; 34: 89-91.

Figure 1 Disposable vasectomy forceps used for Norplant®
removal

Reply
We thank Anne Bennett for her comments1 related to our article describing removal
techniques for contraceptive implants.2

Many primary care organisations are
bringing in ‘single-use instruments’ policies as a
result of new NHS guidance on decontamination
aimed at improving the quality of surgical
instrument reprocessing across the health care
sectors in England. Finding manufacturers who
are prepared to supply small numbers of specialist disposable surgical instruments is
difficult, but we have good news.

Disposable modified vasectomy forceps
can now be obtained for about £2 from the supplier
mentioned below. This company is also making
now be obtained for about £2 from the supplier
mentioned below. This company is also making

Termination of pregnancy and after-
pregnancy care: a teaching guide
for all letters. Letters may be submitted to the
Editor or the Journal Editorial Office (details on
page 205).

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Reference
1 Bennett A. Norplant removal forceps [Letter]. J Fam Plann Reprod Health Care
2008; 34: 272-273.

Reference
1 Coolong H, Dunster W. Nurse intrauterine device training.

Underuse of the IUD
I read the article on the underuse of the
intrauterine device (IUD) in the July issue with
great interest and noted that none of the
references are prior to 1983. That is 25 years ago,
however the real blow to the IUD’s popularity
was in the late-1970s when the Dalkon Shield10
was pilloried and vilified as a source of pelvic
infections and infertility, on what I believe was false
scientific evidence. At that time there was a UK
IUD network, organised by Professor R Snowden
of Exeter University to which 20 major family
planners in the UK belonged.

Every device fitted and every subsequent
patient visit was recorded and sent to Exeter. In
1977, over 40 000 fittings had been recorded, of
which 7282 were Dalkon Shields. There were

only two cases of pelvic infection and both were
cases known to me in Glasgow: one in a
prostitute with gonorrhoea and the other in a
woman who had tried to abort herself with a
knitting needle. As a direct result of organised
adverse publicity the manufacturers of the
Dalkon Shield went out of business and the
reputation of all IUDs worldwide suffered a
slump from which it has never recovered. A
similar campaign, against Depo-Provera13 was
mounted from the USA in the early 1980s and
injectable methods never achieved the popularity
they deserved for commercial reasons.

Women are ill-served by ‘market forces’.

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Glasgow Health Board 1980–1990, Glasgow,
UK. E-mail: libbyswilson@doctors.net.uk

Reference
1 Edouard L. Contrarations for intrauterine contraception.

Nurse IUD fitting
We are writing to respond to the Personal View
article by Bennett and Dunster entitled ‘Nurse
intrauterine device training’ that was published in
the July issue of the Journal.1 We wholeheartedly
endorse the positive experience expressed within
this article as nurses who are recognised trainers and experienced in IUD
insertion to supervise the training of
doctors’ as this underpins the work the FSRH
Associate Nurses Working Group has been
undertaking recently. However, we felt the need to respond to the not-so-positive comments about the
Royal College of Nursing (RCN) guidance being “absurd in requiring the learner to observe
the trainer doing five insertions in patients: one
is usually sufficient ...”. The RCN has been
instrumental in the development of guidance in
order to enable nurses to become training
providers and has specifically demonstrated its support in
enabling nurses working at a higher or specialist
level within the area of contraception and sexual
health to undertake the removal and insertion of
intrauterine techniques (IUTs) and implants.

Without this guidance, nurses who were
performing these procedures, or who wished
to do so, were opening themselves up to litigation
should an error occur. The rationale behind the
guidance stating five insertions is in the fact that
some nurses (i.e. gynaecology nurses) may not
have ever had the opportunity to observe an IUT
insertion in practice.

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Reference
1 Cooling H, Dunster W. Nurse intrauterine device training.

Pharmacy-based sexual health
services and clinical governance
I read with interest the Editorial by Beth Taylor in
the July issue of the Journal.1

I agree that the time is right to develop vision
towards additional providers of the sexual
health service. The new pharmacist’s contract is a
welcome development in this direction.

As Beth Taylor highlighted, there is certainly
a need for educational and training support from
specialist services in order to avoid isolation.
One way of developing a robust professional
link would be the development of a linked Clinical
Governance Plan with local specialist services.
This will not only assure a safety net but also help
in continued development of such services. This
would need to be thought out and planned
carefully at the primary care trust (PCT) level.
Moreover, treatment and patient group directions
(PGDs), especially for STIs, would have to be
thought in the light of the recent alert on
high-level azithromycin resistance of
Neisseria gonorrhoea. Other issues such as
partner notification would also need to be
resolved through training input and professional
pathway with local specialist services.

Another concern would be the prescription
price for medications, which already are free on
the NHS. It would be an opportunity to work with
the local PCTs to explore whether they would be
willing to support some/all of the costs associated
with a pharmacy site for Level 1/2 Sexual Health
Service delivery. The uptake of the newly launched
chargeable repeat contraception service would
give an indication of clients’ willingness to pay
for such services.

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Care Trust, Denton, Manchester, UK.
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Reference
1 Taylor B. Developments in pharmacy-based sexual health services.

Treatment of perimenopausal
menorrhagia with Implanon®
I write concerning the successful treatment of
perimenopausal menorrhagia with Implanon® in
a 53-year-old woman. The patient (date of birth early 1953) was seen at the surgery in
October 2004 with symptoms of flushing and regular
periods. In early 2006 she developed
menorrhagia, which was investigated with
normal hysteroscopy and intrauterine system
(IUS) insertion in early August 2006. The
IUS was expelled after 2 months in situ and after ongoing symptoms of polymenorrhagia.
After some discussion with the patient regarding
treatment options, she decided to trial Implanon insertion, aware that it was not a clinically
recognised treatment option for menorrhagia.

The insertion was carried out in early October 2006.
On review in August 2008 the patient noted light
bleeds in March and April 2007, and a 2-day light
bleed in May 2008. She stated that she “would be willling to recommend Implanon anyday”.

I plan to write to the manufacturer concerned,
namely Organon, concerning this important clinical effect of Implanon in the treatment of
perimenopausal menorrhagia.

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LETTERS TO THE EDITOR

Letters to the Editor are welcome and generally
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Treatment of perimenopausal menorrhagia with Implanon®

Liz Grant

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