Letters to the editor

severe subserosal inflammation without mucosal inflammation leading to the conclusion that the source was elsewhere within the abdomen or pelvis. It is speculative that this episode 4 years earlier might have resulted from the long-term presence of her IUD. Pelvic actinomyces is normally begins as subacute or chronic disease, months or years before presentation.3

Intrauterine contraceptive devices marketed in the UK have licensed durations of 5, 8 or 10 years. In women aged under 40 years it is recommended they are changed according to licence. If inserted after the age of 40, however, they may remain in situ until 1 year after the menopause if the last period (LMP) is over the age of 50 years, or 2 years after the LMP is under the age of 50 years.3 These recommendations are based on expert opinion and acknowledge that insertion-related risks are minimised by reducing the frequency of IUD changes. National guidance places strong emphasis on when removal is safe from a contraceptive point of view.2 There is no clear mention of the need for removal once the contraceptive action is no longer required, or of the risks of failing to do so. The frequency of IUD changes, the number of women in the catchment area, the number of women in the age group of 40 years and the menopause. This is not included in existing guidance.5 The number of women in the UK in the age group of 40 years and the menopause for cervical smear tests. She claimed that she had already had very large attacks, which triggered the attacks, however this seems unlikely. The patient had already had very large attacks, which approximated most closely to a cluster attack without hormones. She says the pain was the worst toothache ever. Associated with the pain was severe subserosal inflammation without mucosal inflammation leading to the conclusion that the source was elsewhere within the abdomen or pelvis. It is speculative that this episode 4 years earlier might have resulted from the long-term presence of her IUD. Pelvic actinomyces is normally begins as subacute or chronic disease, months or years before presentation.3

We cannot provide any denominator data for the number of women in the catchment population with a long-term IUD, but the occurrence of a cluster of cases of serious intraperitoneal sepsis in a single hospital in a relatively short space of time is unusual. It is likely that single cases are not reported, or the association with the copper IUD overlooked, by surgeons and not fed back to those providing contraception services. When a pelvic mass or abscess, fever and other signs of infection are found in patients with a long-term IUD, pelvic actinomyces should be considered. Awareness of this could usefully be increased among general surgeons and gynaecologists. We recommend that current guidelines be revised to include some emphasis on the importance of timely removal of an IUD, once its contraceptive properties are no longer required. Women should be made aware that long-term retention may rarely result in serious infection with pelvic actinomyces and/or actinomyces. There should be more emphasis on timely removal of an IUD early in the menopause. This is not included in existing professional guidance2 and patient information leaflets.3

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Reply

With regard to the four cases of serious pelvic infection described by Pillai et al.,3 the Clinical Effectiveness Unit (CEU) acknowledges that long-term retention of an intrauterine device (IUD) is associated with infection and that the risk of actinomycotic pelvic abscesses increases with duration of use. For this reason, Faculty of Sexual and Reproductive Healthcare (FSRH) Guidance recommends that an IUD is removed at the end of its licensed duration or when no longer required.4 In women having an IUD inserted between the age of 40 years and the menopause, FSRH Guidance recommends that, based on expert opinion, the risk of infection in the 20 days following replacement of an IUD outweighs the risk of extending use until the menopause. In this situation, the CEU recommends insertion of a new IUD after the last menstrual period (LMP), or 2 years after the menopause if the LMP occurs under the age of 50 years.2

Intrauterine Contraception

Case reports are useful evidence of where no other evidence exists. We would encourage others to report complications that are particularly rare, serious or associated with prolonged contraceptive use.

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References

IUS producing a TAC

I recently saw a very unusual patient in whom an intrauterine system (IUS) appeared to produce a trigmoidal aeghemen (TAC). The patient, a 39-year-old woman, was fortunate never to have had a headache until the events reported here. In early 2007, the patient started to complain of severe menorrhagia. Her periods were heavy and lasted for 12 to 14 days, and necessitated the use of 15–20 sanitary pads a day. Tranexamic acid 1000 mg qds was tried initially for 8 weeks but the heavy bleeding continued. New therapy was quickly tried: use of 500 mg tid was tried for many months resulting in a mild improvement. In desperation, the patient was referred to a gynaecologist who felt that the next step was to insert a levonorgestrel-releasing IUS. This was duly done. Within 6 hours of inserting the IUS the attacks started. All the patient’s attacks (averaging 5–7 attacks/day) were similar. All attacks were left sided and of moderate severity. An attack started with pain to the side of the left eye that the patient described as unbearable, like the worst toothache ever. Associated with the pain was profuse tearing from the left eye, although the pain was so bad the patient also cried with her right eye. Her palpable fissure narrowed, her nose ran and her eye became pink. Her face felt strange and numb though painful. Touching her face, or brushing her hair or her teeth, did not trigger an attack. The attacks continued daily for 4 weeks until the patient came to me.

As she entered the room, an attack started. Following the attack I removed the patient’s IUS very easily and gave her a zolmitriptan nasal spray. In case she had further attacks I suggested she see her 7 days later, at which time she appeared to be a completely different person. She had suffered one further attack some 6 hours after the IUS was removed and had injections of nasal spray. After this her attacks had totally stopped. At that clinic visit, in order to help her menorrhagia, which still raged, I started the patient on norethisterone again. Eighteen months later she is still totally free of attacks, and although her bleeding is still very heavy, she is not prepared to even consider allowing me to reininsert an intrauterine device/system, with or without hormones. She says the pain was the worst pain she could ever imagine and as a result she would never, even for the purposes of research, have an IUS inserted again.

This woman appeared to develop a TAC, which approximated most closely to a cluster headache, though sequelae were not present. It might be argued that it was not the IUS itself, but the hormone present in the IUS, which triggered the attacks, however this seems unlikely. The patient’s attacks occurred in the 20 days following insertion of the IUS, and no further attacks occurred until 1 year after the menstrual period (LMP), or 2 years after the menopause if the LMP occurs under the age of 50 years.2

IUS producing a TAC

Perforation of the uterus is a rare complication of intrauterine device (IUD) fitting. It is quoted as occurring in up to 2 in 1000 IUD insertions1 and postpartum insertion up to 6 months after delivery.2 Perforation may occur during the sounding of the uterus or the device itself may perforate the uterus. This can lead to the device being free in

Informed consent for IUD fitting

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IUS producing a TAC

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