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 actinomycosis normally begins as subacute or chronic disease, months or years before presentation.

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 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 if the LMP is under the age of 50 years.2 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 of the IUD is safe from a contraceptive point of view.3 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 the first report occurred in 1973. However, Actinomycetes also normally reside in the female genital tract.2

We cannot provide any denominator data for the occurrence of infections 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 actinomycosis 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 pelvic infection with pelvic actinomycosis and/or actinomycosis. There should be more emphasis on timely removal of an IUD early in the menopause. This is not included in existing professional guidance1 and patient information leaflets.5

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the abdominal cavity, necessitating removal by laparoscopy or laparotomy. Faculty Guidance tells IUD fitters that they should explain the risk of perforation to women considering an IUD and document this discussion in the clinical record. This fits with General Medical Council (GMC) guidance on informed consent. 

I dealt with a complaint from a woman who had a perforation of the uterus following an IUD change; this lady required laparoscopy to remove a missing IUD. The perforation was diagnosed at her IUD check, when the threads were found to be missing. Despite a clinical record showing “perf” followed by a tick this lady alleged that she had not been made aware of the risk of perforation and that if she had been aware she would not have had an IUD fitted.

Dealing with this complaint led me to review my own clinical practice and to seek the opinions of other IUD fitters. Using a questionnaire, 15 instructing doctors were asked about the manner in which they (1) explain perforation risk to women and their confidence doing this and (2) assess their patients’ understanding of the risk of perforation.

These doctors all explained the risk of perforation to all women on their first IUD fitting but only 80% did on subsequent fittings. They commonly used an explanation along the lines of: “There is a small chance – 1 in a 1000 – of perforation. This means making a hole in the wall of the womb. This is not serious but if the IUD goes into the tummy outside the womb it has to be removed with keyhole surgery”. An explanation such as this would meet GMC consent guidance (i.e. you must tell patients if an investigation or treatment might result in a serious adverse outcome, even if the likelihood is very small). 

Although 50% of doctors found perforation easy to explain only 20% felt that their patients had understood the risk of perforation. If this is the case then this would not meet guidance that “you should check that a patient understands the terms that you use, particularly when describing the seriousness, frequency and likelihood of an adverse outcome”. No doctor felt that patients were deterred from having an IUD fitted by the risk of perforation. More than 50% of the doctors felt that they would like further training in the discussion of risk of perforation of the uterus and of explanation of risk in general.

It sometimes takes a review of everyday practice to identify a learning need. In this case it was prompted by a complaint from a woman who unfortunately did experience uterine perforation following an IUD change. All the doctors questioned did discuss the risk of perforation at a first IUD fitting but not all did at a subsequent IUD change. We should not assume that a woman will remember the potential complications of IUD fitting from a previous consultation.

The management of this particular complaint and the results of this survey have changed the way in which I discuss perforation risk with women, and I now incorporate this into a fuller explanation of how the device is introduced and why a problem might occur potentially leading to perforation.

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