suggest that this was not in the patients’ best interests given that it contradicts the advice of the RCOG and the Charing Cross Hospital GTN website.

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References

Resolution of localised lipoatrophy at the site of Implanon® insertion
I have previously reported a 40-year-old woman who had an Implanon® implant into her right upper arm. At the site of the Implanon in the middle of the inner aspect of her right upper arm it was noticed at the time of implant removal 3 years later that she had a localised area of lipoatrophy extending approximately 2 cm either side of the implant along a line of length approximately 15 cm extending above and below the ends of the implant. In this 4 x 15 cm area there was virtually no subcutaneous fat. The lipoatrophy had been asymmetrical and had no effect on the patient who had to have the area of lipoatrophy demonstrated to her.

Six months after removal the area of lipoatrophy had completely resolved and the patient remains asymptomatic. Both arms looked the same with return of the subcutaneous fat on the affected side. It has been suggested2 the lipoatrophy might have been induced by topical steroids, but a review of the patient records shows they have not been prescribed over the last 8 years and the resolution of the lipoatrophy after removal of the implant does not fit with this cause.

I suggest that localised lipoatrophy is added to the rare side effects described for Implanon and that the possibility of it developing, even if it is reversible, further motivates correct placement of the implant.

Peter Lindsay, FRCP, FRCGP, BSc
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References

Letters to the editor

Use of an expired Cu-IUD
I was ready to fit an intrauterine device (IUD) in the CASH clinic when the nurse announced that the expiry date of the Flexi-T 300® was 6 months previous. Having already opened the pack, I continued to fit the IUD to save National Health Service money, convinced by the knowledge that many years ago at an update conference I had heard an expert panel state that it is safe to use an IUD up to a year after the expiry date. Common sense dictates that an expired Cu-IUD is not the same as expired sandwiches, for example.

Shortly after this episode occurred I was on annual leave. During my holiday, one of my colleagues contacted the patient and subsequently replaced the IUD, informing the patient that there was a risk of pregnancy. I was surprised at this since I am aware that there are a number of problems associated with IUD fitting and removal per se. One could argue that the IUD could have been left in situ for 4.5 years instead of the normal 5 years.

It would be interesting to know whether any other Journal readers have used an expired IUD and, if so, what the outcome was. Was my colleague right to replace the IUD on this occasion?

Rajendra Prasad Yadava, FRCGP, FFSRH
Senior Clinical Medical Officer, Morton Surgery, Longton, UK
E-mail: rajendra.yadava@northstaffs.nhs.uk

Reply
I would like to respond to Dr Yadava’s letter on behalf of Williams Medical Supplies, a manufacturer of copper intrauterine devices (IUDs). Most Cu-IUDs have an expiry date of around 4 years. This is because the product’s sterility can be guaranteed over this time frame. Once the expiry date has passed, the product is no longer guaranteed to be sterile and therefore we would not recommend fitting an expired IUD in a patient because of potential infection concerns. If an expired product is fitted by mistake, then there are two courses of possible action. One would be to undertake close patient observation over an agreed time span to ensure infection has not occurred. The second option would be to remove the IUD and fit a new one that is within its expiry date.

April Jones
Category Manager – Pharmaceuticals & Family Planning, Williams Medical Supplies Ltd, Tredigur, UK. E-mail: april.jenkins@wms.co.uk

Reference

Reply
I would like to respond to Dr Yadava’s letter on behalf of the Clinical Effectiveness Unit of the Faculty of Sexual and Reproductive Healthcare. We are not aware of any evidence or
recommendation that intrauterine devices (IUDs) are safe to use after the manufacturer’s expiry date. Guidance from the Medicines and Healthcare products Regulatory Agency (MHRA) states that if medical devices advise checking before use whether a device is within its expiry or use-by date. Training material from Family Health International indicates that the expiration date printed on IUD packaging indicates the date when the sterile package expires, not the date when the IUD’s effectiveness expires. Even in the absence of such warnings for which information is intended, it is advised that an IUD is used only if the sterile package has not expired.

Confusion has possibly arisen because in contraceptive literature the term ‘expiry date’ is often used to describe the limit of an IUD’s recommended duration of use. This ‘expiry date’ can be exceeded in women who are over the age of 40 years at the time of insertion.4

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Correspondence about the recent article on ‘Nurse Training in Sexual and Reproductive Health’

The Journal has received a number of letters written in response to the Personal View article entitled Nurse training in sexual and reproductive health4 by Shelley Mehigan, Wendy Moore and Linda Hayes that appeared in the January 2010 issue of the Journal. The very fact that this article has attracted the greatest number of letters and comments published in the Journal in recent years is evidence of the article’s timeliness and relevance to many of the Journal’s readers. The individual letters received by the time this letter was written, are reproduced in full. They are from Shelley Mehigan and Wendy Moore, are reproduced here in full.

Letters

I would like to thank the authors of the article on nurse training in sexual and reproductive health in the January 2010 issue of this Journal for very clearly setting out the current situation regarding nurse training in this specialty and the history to the situation. I agree with the authors that post-registration training in sexual and reproductive health has been an area of concern for some years now. Certainly when I joined the Faculty Associate Members Working Group 3 years ago this was one of our key issues and it was our agenda. We looked to see whether nurses could do the Faculty Diploma (the DFFP as it was known as then) along with doctors. This was not possible as it is a medical diploma and qualification. This has come full circle and will be revisited. A lot of work has taken place within this group, including attempting to map current training provided across the country.

Recruitment. As a Senior Nurse in a service employing over 60 SRH nurses I find the lack of standardisation of training difficult when recruiting; to ascertain from applications whether the candidate has completed a recognised training or an in house training course can be difficult, in addition ‘recognised’ courses can vary significantly. From the nurse’s point of view there seem to be enthusiastic candidates who have not attended antenatal classes and only modified the guidelines for prone and sexual health but who are keen to move into the specialty and it seems some nurses are having difficulty in knowing exactly which training is required by employers and/or accessing the training.

Access to training. From the nurse’s position, to undertake a contraception and sexual health course at a Higher Education Institute (HEI) can take 3–9 months to complete. Managers are reluctant to give study leave to enable nurses to access the training, and nurses are struggling to find the time and the necessary support and clinical supervision to manage their workload. In some instances, after 6 months two modules have been completed and the nurse is trained in contraception, however, access to a course is required to complete cervical cytology screening and yet another for management of sexually transmitted infections (STIs).

Multidisciplinary training. I believe that training in contraception and sexual health should be multidisciplinary. Nurses and doctors should be able to access the same training and undergo the same assessment; it would follow on that standard accreditation is required. The Faculty has welcomed Associate Members with the AMNG working group and with Associate Members represented on other committees. If the Faculty could extend accreditation to clinicians other than doctors this could address many of the issues, although this is currently not possible.

Standardised training. The content of the training must be standardised and it is vital that training from all providers and HEIs is up to date, evidence-based and validated by practicing experts in SRH. The course should cover contraception and sexual health to meet the needs of integrated services. Cytology training and updating is an area where nurses would benefit from standardising across disciplines.

The new e-learning for the DFRSH will be accessible for all to learn in their own time and at their own pace. Assessment would be standard. The Course of 5 may be richer for having doctors and nurses training together. I believe the clinical placement and clinical assessment is a very important part of the SRH nurse training and I would not like to see it reduced. This part of the assessment is not undertaken by HEIs but by local SRH departments. Therefore this could continue and ensure that the nurse is doing a university-accredited course. Locally we provide clinical placements of 12–14 weeks with usually one session a week. If this can be provided with longer sessions within a shorter time period then the clinical training could be completed in several weeks.

Many post-registered nurses are not doing the contraception and subdermal implant training as part of a pathway to get a degree, but to achieve the competencies required to work in the area. For those nurses who choose to do it as part of a degree or a recognised course I think that standardised course should be available at HEIs but I would recommend that the course includes the same basic content as the standard training accessed by doctors and nurses (i.e. the training, Course of 5 and clinical placement).

Accreditation needs to be addressed urgently in view of the Royal College of Nursing (RCN) changes. We plan in future to provide accreditation as a Department of SRH to nurses training in subdermal implants (SDIs). However, this has implications for those who wish to become primary trainers for their medical colleagues.

Rosie Jackson
Senior Nurse/Service Manager, Sexual and Reproductive Health, Levisham PCT, W aldron Health Centre, London, UK. E-mail: rosie.jackson@nhs.net

Reference

I am corresponding in response to the article1 in the Journal on nurse training in SRH, and want to say that I totally agree with all of the points the authors raised in this article.

I am the lead nurse for sexual health in Northamptonshire Healthcare Foundation NHS Trust with 27 family planning (FP) nurses and 23 genitourinary medicine (GUM)/HIV nurses. Training, education and development of their role is one of my key priorities.

In the days of the English National Board (ENB), as the authors quite rightly say, we knew the standards required. Currently we support FP students on courses at De Montfort University Leicester and are very satisfied with this course in terms of standards and support from tutors, and so on. However, there have been students from other areas who have not been as impressed than impressed with the course offered.

I think the proposal to link in with the FSRH standards is an excellent progression, particularly as nurses take on such an integral advanced role in this specialty. With advanced practice, I as a manager like to know that when a new member of staff has attended specific courses, it is at the level required to carry out the job competently and safely.

I welcome involvement in these new initiatives.

Chris Stirmer
Directorate Senior Nurse, Directorate of Sexual Health, Ashworth Centre, St Mary’s Hospital, Kerpen Lane, UK

Reference

I was most interested to read the nurse training article2 in the Journal as I have a particular interest in nurse training as one of my roles at The Margaret Pyke Centre is Nurse Trainer for inserting and removing subdermal implants. I am also training to be a Faculty Nurse Trainer for Doctors in this specialty.

It seems to me that the Royal College of Nursing (RCN) are implementing policies that potentially discourage these Trainees, by the large increase in accreditation and re-accreditation fees. Primary care trust budgets seem too tight that they are not providing the money for the fees, so that the only way for a nurse to obtain accreditation is to pay for it herself. The nurses that I have trained have had difficulty in affording the fee of £35 (£75 for non-RCN members), so I have put an extra fee of £300 (£400 for non-members) is going to cause it. It is definitely going to reduce the number of nurses coming forward for the programme. Furthermore, this disincentive to increasing the pool of competent people is contrary to the stated policy of promoting long-acting reversible contraception (LARC).
Reply

Louise Melvin

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