Progesterone receptor modulators
The review on ‘Progesterone receptor modulators in gynaecological practice’ in the April 2010 issue of the Journal is a valuable contribution to the available literature on a currently important subject. In the section on ‘Contraception’ the authors have dealt at length with mifepristone. Since the latter is not licensed for postcoital contraception, it is not surprising that the authors dealt with some salient features of the recently introduced second-generation selective progesterone receptor modulator, ulipristal acetate, which is licensed for postcoital contraception for up to 120 hours after unprotected sexual intercourse.

The primary mechanism of action is inhibition of ovulation, but alterations in the endometrium also have anti-implantation effects. Ulipristal acetate appears to be a more potent inhibitor of ovulation than levonorgestrel and hence may be relatively more effective as a method of postcoital contraception.1,2

While the post-implantation use of levonorgestrel has not been associated with any harm, it is not yet the case that levonorgestrel has not been established for ulipristal acetate.3

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References
4 Crociato HB, Brache V, Pavao M, Coelho L, Forcellini P, Fila et al. Ulipristal acetate therapy following the standard levonorgestrel emergency contraceptive dose or a single 0.75 mg dose given on the days preceding ovulation. Contraception 2004; 70: 442–450.

Reply
We thank Dr Bhathena1 for his interest in our recent review article.2 The purpose of the review was to highlight the many different indications in gynaecological practice, in which progesterone receptor modulators (PRMs) may be applied and to focus on the potential health benefits of PRMs. PRMs have an endometrial antiproliferative effect in the presence of follicular phase estrogen levels, and this constitutes the basis of many of their potential advantages in the management of gynaecological conditions. Currently, the only licensed indications for PRMs are the prevention of pregnancy and ulipristal (UPA) for emergency contraception (EC) both relate to fertility control. Ulipristal has only recently received a licence based on good evidence of its effectiveness for EC2,3,4 when taken up to 120 hours after intercourse.3,4

This Journal has previously published very informative commentaries and correspondence on postcoital contraceptive methods.1 The authors of this paper pointed out that regarding the mechanism of action, an effect of UPA on the endometrium could not be ruled out although the effect on ovulation inhibition is potent. With respect to any potential harmful effect on pregnancy, it is reassuring to note that the rate of reported pregnancy in women treated with levonorgestrel and UPA for EC was not different.

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References
7 Mansour D. EllaOne: a second-generation emergency contraceptive dose or a single 0.75 mg dose given on the days preceding ovulation. Contraception 2004; 70: 442–450.

Nurse training in SRH
I have just read the Personal View1 on ‘Nurse training in SRH’ in the January 2010 issue of the Journal and I agree with most of what Shelley Mehigan and her colleagues have written. It would seem sensible that sexual and reproductive healthcare (SRH) training is unified for all health practitioners, such as virologists and biochemists, and they are not necessarily required to have a medical qualification.

3 Royal College of Surgeons of Edinburgh
The DMC (Diploma in Immediate Medical Care of Obstetric Anaesthetists and Obstetricians) is open to doctors, nurses and paramedics working in this field.

4 Society of Apothecaries
The Diploma in the Forensic and Clinical Aspects of Sexual Assault (DIPFS) is relevant to the role of the forensic medical practitioner.

5 University diploma courses
Many of the University diplomas are open to a wide range of health care professionals [e.g. the Diploma in Palliative Care of Cardiff University (nurses, doctors) and the Diploma in Medical Law at Northumbria University (nurses, managers, lawyers, doctors)].

6 Medical Royal Colleges and Nurse Training
There should be no great impediment to the Medical Royal Colleges working more closely together with the RCN and universities on unified nurse and doctor training in shared fields.

The Royal Charter of the Royal College of Obstetrician and Gynaecologists (RCOG) states the purpose is: “The encouragement of the study and the advancement of the science and practice of obstetrics and gynaecology.” This is a broad definition and should allow the RCOG and the FSRH to take a progressive view of joint training.

In conclusion, I fully support the Personal View, and would be happy to discuss it further with the authors. I will also be interested to hear about future progress on this issue.

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Reference

Need for IUD fitters to have expertise in resuscitation
I was interested to read the Personal View1 on ‘Nurse training in SRH’ in the January 2010 issue of the Journal.

We have a related issue at the moment, with the introduction of contraceptive services from other health care providers. It concerns the Faculty’s guidance on resuscitation for nurses when fitting IUDs.2 It suggests someone competent to give intravenous (IV) drugs must be available. The Royal College of Nursing (RCN) has also made a statement3 supporting this but when contacted the RCN said it supported it because it was Faculty guidance and didn’t seem to understand the consequences or practicalities. It would appear that there is no named person to discuss this matter with there.

We currently have nurse-led community clinics that provide intrauterine devices (IUDs/IUSs) with no doctor present. Indeed we have very few doctors in such clinics.

None of us have ever cannulated or given IV drugs (including me for over 20 years). Some people have taken blood from time to time but none of us have any need to do so regularly. We are required to be competent in basic life support (defibrillation) and cardiopulmonary resuscitation (CPR). I am sure that many readers in this group will be similarly experienced.

I would like to ask whether the Faculty considers nurse-led clinics resuscitation a matter requiring expertise or training.

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