experience at IV administration. Perhaps we are unusual in that so many of our nurses do so many procedures.

Do any ... including the physiology of the

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References
4 Service Standards for Resuscitation in Sexual Health Services.

Reply
I would like to thank Drs Hollingworth and Mansour for their letters about nurse training and the need for intrauterine device (IUD) fitters to have expertise in resuscitation.1,2 This is a question that I am being increasingly asked by clinicians around the country as they become aware of the implications of recent guidance on this topic. Not only is it unrealistic to expect all the clinicians involved to undertake the extra training and regular practice to comply with the guidance – looking at the British Resuscitation Council guidelines,3 doing what is advised would need advanced life support (ALS)-level training with regular practice of the techniques – it also has implications as to how services can be delivered not just by nurses but by doctors too. Many services will feel it is unworkable. Those that have tried, like Dr Hollingworth, to ask the Royal College of Nursing to produce guidance, have been referred to the Faculty guidance,4 and the Faculty rightly feel that they were following advice from the RCN.

As I understand it, the original guidance from the RCN,5 which was directed at nurses fitting devices rather than assisting other clinicians and was based on discussions with the RCN legal team, advised that a local risk assessment based on how often they felt a problem might arise? Would we insist on the same restrictions for doctors fitting an IUD/implant? Why might we treat nurses differently?

Issues to consider include:
- Should the nurse fit an IUD very late in the evening?
- If the woman has had a difficult fitting in the past?
- Is there a need to have another registered practitioner (another nurse or doctor) in clinic?
- If a woman had rushed in and had not eaten for hours, and so on?

Perhaps the way forward would be for one or more groups of nurses to produce guidance for use by all clinicians to follow in such scenarios. This would reflect the multidisciplinary aspect of the work and recognise that this could apply to either doctors or nurses, both groups having highlighted that this is an area where few currently feel able to undertake the actions suggested in the current guidance. If this guidance could be produced following discussion with experts in the field of resuscitation it would then hopefully be realistic, as well as being practical, and would reflect current evidence-based best practice.

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References
1 Hollingworth B. Need for IUD fitters to have expertise in resuscitation (Letter). J Fam Plann Reprod Health Care 2010; 36: 179–180.
2 Mansour D. Nurse training and the need for IUD fitters to have expertise in resuscitation (Letter). J Fam Plann Reprod Health Care 2010; 36: 180.

Letters to the editor

Safe sex during pregnancy

As a consultant in genitourinary medicine, I wish to comment on Dr Young’s article7 to have sex in.”7

In a recent issue of the Journal.

The second point made is that “if either partner has a sexually transmitted infection (STI), they should use protection ...”. If one of a couple has an STI then it is generally recommended that for any treatable infection a couple discontinue completely from having any penetrative sex until treatment of both partners is complete. Condoms do not provide 100% protection against any STI and any untreated infections in pregnancy can cause serious consequences.

I am uncertain why protected anal sex should be “avoided altogether”. If the couple exercises good hygiene practice is there any other concern about unprotected anal sex? I could not find anything in the article to explain this advice.

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References

Reply
First, I wish to thank Dr Young for reading my article7 so carefully and responding to it so thoughtfully in her letter.2

Dr Young is, of course, correct that if either partner in a couple has a sexually transmitted infection (STI) they should ideally not have sex at all until after treatment. However, in practice this advice is frequently ignored – particularly during pregnancy when partners want to reinforce their bond and reflect their closeness – so I was being pragmatic in advising protecting pregnancy. Similarly, Dr Young is correct in saying that in ideal circumstances, anal sex is safe. But in the real life situations that I hear about, hygiene practices around anal sex are often far from perfect and so, again pragmatically, during pregnancy in particular I generally advise avoidance.

Firstly, the aim of my article, and the substance of the main body of my text, was to promote sex in pregnancy and ask professionals to encourage it. I didn’t aim to give detailed information about risks – such information is covered fully in many other sources. Hence the guidance provided in the summary boxes gives headlines only rather than explaining in full the medical background.

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References
2 Young S. Safe sex during pregnancy (Letter).

e-SRH e-Learning

As an Instructing Doctor for the Faculty of Sexual and Reproductive Health Care (FSRH), I have enjoyed completing this online training7 at www.e-lfh.org.uk.

This is an excellent course, and the animations, including the physiology of the
Safe sex during pregnancy

Susan Young

*J Fam Plann Reprod Health Care* 2010 36: 180
doi: 10.1783/147118910791749281

Updated information and services can be found at:
http://jfprhc.bmj.com/content/36/3/180.3.citation

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