experience at IV administration. Perhaps we are unusual in that so many of our nurses do so many procedures. Do any readers have a similar experience to this? Is there written by Dr Barbara Hollingworth clearly robust, be based on sound evidence and the Journal.

1 Mehigan S, Moore W, Hayes L. Nurse training in Newcastle and North Tyneside, Community and her colleagues along with the subsequent correspondence in the April 2010 issue of the Journal.

Nurse training in our specialty needs a nationally recognised and standardised educational pathway producing health care professionals who are fit for purpose. This training must be theoretically and practically robust, be based on sound evidence and the accreditation must not be overly expensive. Our services may still be 'doctor-led' in many parts of the UK, but clinics would come to a grinding halt if nurses are restricted in their practice and become ‘handmaiden’s' once more. The letter written by Dr Barbara Hollingworth clearly illustrates this point.

We have also had local community nurse-based clinics fitting intrauterine contraceptives in general practice premises suspended because ‘doctor cover’ by the general practitioners [who can administer intravenous (IV) drugs] has been withdrawn. Faculty guidance in Service Standards for Intrauterine Contraception does not clearly state that a health care professional proficient in giving IV drugs is available in many parts of the UK, but clinics would come to a grinding halt if nurses are restricted in their practice and become ‘handmaiden’s' once more. The letter written by Dr Barbara Hollingworth clearly illustrates this point.

I have recently asked over 70 health care professionals who fit intrauterine contraceptives about their use of atropine and no one has administered it. I have on one occasion in the last 22 years when a woman was very keen to keep an IUD fitting devices rather than assisting other clinicians and was based on discussions with the RCN legal team, nurses should make 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 present or 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

3 British Resuscitation Council guidelines, doing what is advised would need advanced life support (ALS)-level training with regular practice of the techniques – it also has implications for 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 (RCN), have been referred to the Faculty guidance, and the Faculty rightly feel that they were following advice from the RCN.

As I understand it, the original guidance from the RCN, 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?

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Safe sex during pregnancy

As a consultant in genitourinary medicine, I wish to comment on an article1 that it is so difficult to have sex? In Susan Quilliam’s Consumer Correspondent article2 in the April 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 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 carry 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 avoiding unprotected sex? I could not find anything in the article to explain this advice.

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Reference


Reply

First, I wish to thank Dr Young for reading my article1 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 practical in advising protection in pregnancy. Similarly, Dr Young is correct in saying that in ideal circumstances, anal sex is safe. But in the real-life situations I feared that hear about, hygiene practices around anal sex are often far from perfect and so, again pragmatically, during pregnancy in particular I generally advise aversion.

Finally, 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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Letter to the editor

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The rationale for these changes is partly explained in an article by Trussell et al.3 Obesity is generally perceived to be an important risk factor in CHC users because of the high relative risk of venous thromboembolism (VTE). Trussell argues that, in terms of absolute or attributable risk, other cardiovascular risk factors are more strongly associated with VTE and mortality than obesity. Furthermore, the absolute risk of VTE in CHC users aged 45–49 years (UKMEC 2) is 175 per 100,000, which is greater than a VTE risk of 105 per 100,000 associated with CHC use and body mass index (BMI) = 35 (UKMEC 3). The risks in terms of deaths in CHC users are even lower, with an absolute risk of 3.3 deaths per 100,000 in smokers aged <35 years (UKMEC 2) and a risk of 0.05 per 100,000 in women with BMI≥35 (UKMEC 3).

With regard to the UKMEC 2009 section on multiple risk factors for cardiovascular disease, the text is unchanged from UKMEC 2005. The additional comments do appear to imply that the UKMEC definition of ‘older age’ is aged 40 years or above. Risk factors such as age are a continuum and there is not necessarily an exact cut-off. As Dr Lee acknowledges, UKMEC is only a guidance document, and it would be entirely appropriate for clinicians to apply their own clinical judgement.

Louise Melvin, MRCOG, MFSRH
Director, FSRH Clinical Effectiveness Unit, and Consultant in Sexual and Reproductive Health, Sandford, Glasgow, UK.
E-mail: louise.melvin@nhs.net

References
2 Faculty of Sexual and Reproductive Healthcare. UK Medical Eligibility Criteria for Contraceptive Use (UKMEC 2009)2 the Category 4 for body mass index (BMI)≥40, has been removed? As a raised BMI is so closely associated with increased risk of venous thromboembolism, this does not seem logical. Without the Category 4 status, I am concerned that increasing numbers of patients with a BMI≥35 and indeed a BMI≥40, will start, or continue to take, the combined pill, without any robust guidance to support this as a dangerous practice.

I am, however, pleased to see the Category 3/4 for multiple risk factors for cardiovascular disease is now clearly stated. I would, however, prefer the definition for ‘older age’ to be stated. I would interpret this as being aged 35 years or over, but the additional comments at the end of the section imply the definition is aged 40 or above.

I fully appreciate that UKMEC is a guidance document and not a list of rules as such, but if these are too loosely presented then they will not serve their purpose in ensuring safe prescribing practice.

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Reference
1 Faculty of Sexual and Reproductive Healthcare. UK Medical Eligibility Criteria for Contraceptive Use (UKMEC 2009)2 the concentration of contraceptive hormones may change by concomitant drug use and vice versa. It is good practice to enquire about current and previous drug use (specifically liver enzyme-inducers) when offering hormonal contraceptives.1 Would you consider that some drugs might reduce hormonal contraceptive effectiveness. With the exception of the progesterone-only injectable or the levonorgestrel intrauterine system, the contraceptive efficacy of hormonal methods is reduced by liver enzyme inducers.1

Some ARVs, such as protease inhibitors (amprenavir, atazanavir), saquinavir, ritonavir) and non-nucleoside reverse transcriptase inhibitors (efavirenz, nevirapine), are metabolised by the CYP3A4 liver enzyme system and can affect the plasma levels of the contraceptive hormones.

Each Implanon contains 68 mg etonogestrel (ENG). The subdermal delivery method makes it 100% bioavailable. Serum ENG concentrations increase rapidly within 8 hours of insertion and peak after 4 days.2 The release rate is 60–70 µg/day in weeks 5–6 post-insertion, and decreases to 35–45 µg/day at the end of the first year, to 30–40 µg/day at the end of the second year, and then falls to 25–30 µg/day at the end of the third year.3,4 These low concentrations are sufficient to inhibit ovulation for 3 years.5

The advice for using a progesterone-only implant for women on long-term liver enzyme-inducing drugs is to continue using it together with additional contraceptive protection (such as condoms) and for 4 weeks after the drugs are stopped.1

These cases highlight the unforeseen consequences of non-disclosure of HIV for both patients and physicians. One of the dilemmas facing physicians is whether to disclose the HIV diagnosis to general practitioners (GPs). Arguments have been advanced for specialists being better informed confidentiality and notifying the GP against patients’ wishes in the interest of normal medical practice, the patients’ and health personnel best interests, and the interests of society in general. Gillon6 examines each argument and concludes that none is sufficient to justify violating physician patient confidentiality in most cases.

Early contraceptive failure of Implanon in a woman on antiretroviral medication has been described.4 The patient in the case report had an ectopic pregnancy. The majority of HIV-positive women are of reproductive age. Contraceptive options must take into account the risk of an unintended pregnancy, vertical transmission, and horizontal transmission for a newborn. Only if doctors can achieve all these goals, a combined contraceptive (barrier method plus another method) is the ‘gold standard’. Some practitioners will argue that the ‘Double DUTCH’ advice should be given to all patients and not just HIV-positive women.

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5 UKMEC 2009. The concentration of contraceptive

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Michael Tapley

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