menstrual cycle, convey concepts more dynamically than could ever be displayed on paper.

Video consultations demonstrate communication aspects wonderfully. The introductory emphasis on the law, the client perspective and young people places contraception and sexual health within its progression. Links to referenced sites are well chosen and accessible. The interactive self-assessment is challenging and – dare I say – fun, and I learned from some errors but I will not confess where!

I think e-SRH e-Learning is good preparation for the Practical Sessions of the FSRRH Diploma,² and with regular updating it will remain a valuable educational resource for us all in the future. Congratulations to all the team involved with this project.

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References

Letter to the editor

Query about Faculty updated UKMEC

I would be grateful if the Faculty of Sexual and Reproductive Healthcare could explain why in the updated UK Medical Eligibility Criteria for Contraceptive Use (UKMEC 2009)¹ 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 accept 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 really 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

Reply

In her letter,¹ Dr Lee raises a pertinent question regarding the new UK Medical Eligibility Criteria for Contraceptive Use (UKMEC 2009)² for body weight and combined hormonal contraception (CHC) use. The current Clinical Effectiveness Unit was not involved in updating UKMEC but we believe the body weight categories were made less restrictive to make them more consistent with the categories for other cardiovascular risk factors and CHC.

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. For example, 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 >30 (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 <55 years (UKMEC 2) and a risk of 0.1 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.

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References

Implanon® failure in patients on antiretroviral medication: the importance of disclosure

We would like to draw other practitioners’ attention to an observation recently in our clinic, namely Implanon® failure in two women on antiretroviral (ARV) medication who failed to mention Implanon use to their HIV physicians. This serves to highlight the need for disclosure of HIV diagnosis to physicians. These women highlight the need for 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 clinical issues facing physicians is whether to disclose the HIV diagnosis to general practitioners (GPs). Arguments have been advanced for specialists because of confidentiality and notifying the GP against patients’ wishes in the interest of normal medical practice, the patients’ and health personnel interests, and the interests of society in general. Gillon² examines this argument and concludes that none is sufficient to justify violating patient confidentiality in most cases.

Early contraceptive failure of Implanon in a woman on antiretroviral medication has been described.³ The patient in the case report had an ectopic pregnancy.

The great 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 non-disclosure policy to 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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References
Contraceptive failure and the progestogen-only pill

The case report by Chandler and Nasti in this issue of the Journal is interesting and highlights the need for trials of hormonal contraceptive use to include obese women.

The authors acknowledge that despite an apparent association between contraceptive failure and higher body weight in studies of a Norplant® prototype and a levonorgestrel-releasing vaginal ring, there is insufficient evidence to demonstrate reduced efficacy in heavier women using the progestogen-only pill (POP). Current guidance from the Faculty of Sexual and Reproductive Healthcare (FSRH) advises one progestogen-only pill (POP) per day irrespective of body weight. This recommendation is based on the evidence available at the time of publication and the consensus of the guideline development group.

The recent review of obesity and oral contraceptive failure by Trussell et al lends further support to FSRH guidance. The authors conclude that they “found no convincing evidence that very heavy or obese women have a higher risk of oral contraceptive failure” and recommend that “FSRH guidance on the use of oral contraceptives in obese women should be retained as it is broadly consistent with general medical practice.”

Given that long-acting reversible methods of contraception (LARC) are known to be highly effective and less dependent on adherence than OCs, LARC methods should be offered to all women, particularly following OC failure.

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References

Lost IUD penetrating bladder wall

The incidence of uterine perforation following intrauterine device (IUD) insertion is reported to be between 1 in 1000 insertions.1 Misplaced IUDs can be diagnosed simply with speculum examination. Missing threads is the usual sign and may be due to unrecognized expulsion, enlarged uterus due to pregnancy, the IUD threads becoming detached or, most importantly, an accurate diagnosis of a misplaced IUD is a matter of debate in this case as to whether the uterus was iatrogenically perforated or whether the IUD moved through the uterine wall during pregnancy. This case also demonstrates an uncommon localization of an IUD and the close relationship between pelvic pain and IUD misplacement.

We believe that this is the first case of bladder perforation reported in the scientific literature. It is a matter of debate in this case as to whether the uterus was iatrogenically perforated or whether the IUD moved through the uterine wall during pregnancy. This case also demonstrates an uncommon localization of an IUD and the close relationship between pelvic pain and IUD misplacement. This case also emphasizes the need for regular check-ups following IUD insertion and the need to be suspicious of possible locations other than the uterus. Most importantly, an accurate diagnosis may facilitate the use of endoscopic techniques and result in minimally invasive treatment.

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Figure 1 Cystoscopy and laparoscopic images. (A) Only one thread of the T-copper intrauterine device was found to be penetrating the bladder wall. (B, C) Extraction with forceps resulted in the successful traction of the device except for the base and the threads. (D) Using a laparoscopic approach it was possible to extract the remainder of the device after minimal dissection.
Implanon® failure in patients on antiretroviral medication: the importance of disclosure

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