menstrual cycle, convey concepts more dynamically than could ever be displayed on paper. Video consultations... - 58(6 Suppl.): 91S–97S.

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Letters to the editor

Criteria for Contraceptive Use (UKMEC 2009)

Deborah J Lee,

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UK

Reference

E-mail: Deborah.J.Lee@salisbury.nhs.uk

Sexual Health, Salisbury, UK.

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 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.

Deborah J Lee,

Associate Specialist in Reproductive Health, Lead Clinician CASH, Salisbury District of Sexual Health, Salisbury, UK

E-mail: Deborah.J.Lee@salisbury.nhs.uk

Reference


Reply

In her letter, Dr Lee raises a pertinent question regarding the new UK Medical Eligibility Criteria for Contraceptive Use (UKMEC 2009)2 categories 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 thrombosis (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 instance, 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 0.004 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 judgment.

Louise Melvin,

Director, FSRH Clinical Effectiveness Unit, and Consultant in Sexual Reproductive Health, Sandford, Gloucester, UK

E-mail: louise.melvin@nhs.net

References


3 Trussell J, Schillinger K. Much ado about little: obesity, combined hormonal contraceptive use and venous thrombosis. Contraception 2008; 77: 143-146.

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

We would like to draw other practitioners’ attention to a concerning trend observed 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 highlights the need for disclosure of HIV diagnosis to physicians is whether to disclose the HIV diagnosis to general practitioners (GPs). Arguments have been advanced for specialists breach 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. Gillon4 examines both 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.5 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-coercive method 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.

Nisha Lakhia,

Medical Student, Department of Obstetrics and Gynaecology, Brooklyn Hospital Center, Brooklyn, New York, NY, USA.

E-mail: nilakhi@yahoo.com

Abha Govind,

MSFRH, FRRCOG

Consultant, Department of Obstetrics and Gynaecology, North Middlesex University Hospital, Edmonton, London, UK.

E-mail: Abha.Govind@mnh.nhs.uk

References


Lost IUD penetrating bladder wall

The incidence of uterine perforation following intrauterine device (IUD) insertion is reported to be relatively low (1:1000 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, uterine perforation.2

A 48-year-old woman was admitted to our clinic with a suspected misplaced IUD. She had her IUD inserted 15 years ago in a health cabin by a midwife. She started having pelvic pain following insertion; however, this was attributed to complications of the insertion procedure. Four months after the device was introduced the pain diminished and the woman wondered whether in fact the IUD had dropped out. In order not to damage the bladder mucosa, the IUD threads were broken and pulled during ultrasonography and the handle of the device was extracted during laparoscopy (Figure 1). Postoperatively a catheter was held through the bladder for 1 week. The recovery period was uneventful.

Uterine perforation is a potentially hazardous yet uncommon complication of IUD insertion and can go unnoticed due to anticipation of pain during the insertion procedure. Diagnosis is relatively easy if suspicion is awakened. Pelvic ultrasonography is the first step towards establishing the location of a misplaced IUD. Computed tomography, magnetic resonance imaging, X-ray and fluoroscopy are also useful tools for diagnosis; however, in most cases the diagnosis can be made using only simple pelvic ultrasonography.3

Zakin et al. divided perforation into two groups: complete and partial. They proposed that once partial perforation had occurred, the IUD may transmigrate to the adjacent structures easily.4 Our patient also had multiple pregnancies after IUD insertion. It seems that subsequent pregnancies may have caused the IUD migration. The patient had three deliveries following IUD insertion.

Bleeding problems and menorrhagia are possible outcomes following IUD insertion; however, these symptoms should alert the clinician to other possible complications. Accompanying pelvic pain is also another sign of possible problems. Our patient had pelvic pain for 4 months following IUD insertion and did not attend for a check-up. Because she attributed this pelvic pain to the insertion procedure, the opportunity for an early diagnosis was lost.

Conversely, the patient sought medical help in order to discover whether the device had dropped out and this was associated with decreased pelvic pain following this painful period. Unfortunately, medical staff concurred with the patient’s stated belief that the IUD had dropped out, and so did not perform further investigations to confirm or refute this belief. Interestingly the patient experienced no problems afterwards, until the diagnosis of a misplaced IUD nearly 15 years later.

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.

Mehmet Vural, MD
Assistant Professor, Department of Obstetrics and Gynecology, School of Medicine, Harran University, Sanliurfa, Turkey
E-mail: drmural@yahoo.com

Harun Toy, MD
Assistant Professor, Department of Obstetrics and Gynecology, School of Medicine, Harran University, Sanliurfa, Turkey

Hakan Camuzucoglu, MD
Assistant Professor, Department of Obstetrics and Gynecology, School of Medicine, Harran University, Sanliurfa, Turkey

Burak Sezgin, MD
Doctor, Department of Obstetrics and Gynecology, School of Medicine, Harran University, Sanliurfa, Turkey

References

Figure 1 Cystoscopy and laparoscopy 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

Nisha Lakhi and Abha Govind

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