COMMUNITY GYNAECOLOGY

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Community gynaecology is a new subspeciality within gynaecology and encompasses the disciplines of family planning and sexual health. Basic diploma level training is available for postgraduate trainees in primary care and gynaecology, but in addition there is now specialist registrar training over three years for consultant posts in community gynaecology. In addition, the Faculty of Family Planning (www.ffprhc.org.uk) sets and monitors standards and training in primary and secondary care arenas, maintains uniform standards of care with clinical effectiveness guidelines, and provides ongoing accreditation. Cathy Tupper describes the evolving role of her subspeciality, which has kept many of the aspects of the former family planning services such as walk-in clinics and self-referrals that made the work so variable and the service so accessible.

UPDATE ON CONTRACEPTIVE METHODS

In some sections of the population, contraception is seen as just pills and condoms. Whilst sterilisation is seen as the ultimate, its relative irreversibility should limit use. Other contraceptives bring with them complete reversibility, equivalent or lower failure rates and some desirable side effects such as menstrual control. The only drawback is, as expected, that these newer methods are more expensive, which may limit use.

Combined oestrogen-progestogen preparations

Recommendations for combined contraceptive pills containing oestrogen have been significantly tightened⁽¹⁾. Information about personal and family history in terms of venous thrombosis risks and specific arterial risk assessment are vital, as is the exclusion of liver problems and interacting medications. However, although the options for delivery of the hormones have broadened with the contraceptive patch, and soon the contraceptive vaginal ring, there are significant contraindications for many women. Alternatives are therefore welcome and necessary.

Progestogen preparations

In the progestogen-only sphere, expansion has been significant with the introduction of a new desogestrel-containing pill (Cerazette, Organon Labs). Not only is this easier to take, with a twelve- rather than three-hour window, it is probable that its efficacy is as good as the combined pill, as it also prevents ovulation in contrast to other progestogen-only pills, which rely on inhibition of sperm migration by thickening cervical mucus. A significant percentage of women will stop menstruating on Cerazette, again an improvement on its predecessors, which often cause irregular menses.

Its implantable counterpart, Implanon (Organon Labs), has the lowest failure rate of any contraceptive, including sterilisation, with less than 1 in 10,000 method failures⁽²⁾.

Injectable progestogens are used widely amongst young

women. The advantage of 'forgettable' contraception usually outweighs the still much debated risk of osteoporosis with prolonged use and low oestrogen levels^(3,4).

After many years out of vogue, another 'forgettable' contraceptive, the intrauterine contraceptive device (IUCD), is gaining in popularity. It is now recognised that most infections arise within the first 15 days of insertion, caused by organisms pre-existing in the vagina or cervix. Prior screening is thus recommended if any risk of sexual infection is suspected⁽⁵⁾. The other complications, such as expulsion and perforation, are related to the experience of the fitter; most Primary Care Trusts (PCTs) have taken on the Faculty guidance of a minimum number of 12 insertions per year to maintain competence.

Newer devices such as the frameless copper IUCD (Gynefix, FP Sales Ltd) and the levonorgestrel releasing system (Mirena, Schering Health) cause less problems with menstruation; indeed Mirena is used for menorrhagia as its progestogen content thins the endometrium. The Royal College of Gynaecology (RCOG) guidelines⁽⁶⁾ recommend its use in initial treatment of menorrhagia, and this use has contributed to the 36% drop in hysterectomies for this reason⁽⁷⁾.

For all methods of contraception there is a failure rate expressed as the percentage of women experiencing pregnancy in the first year of using a method – the Pearl Index. This varies from less than 0.1% for sterilisation and the etonogestrel implant, up to 15% for condoms. Where no method is used, 80-90% of women would be expected to become pregnant.

These figures are averaged across all user age groups. The figures for barrier methods of contraception are disappointingly high, especially in the younger age groups. This means promotion of condom use alone cannot be recommended in this age group, the ideal being a double method, ie condoms for sexually acquired infection prevention plus a more effective contraceptive, usually oral or injectable.

NEW SERVICES

Many gynaecologists have no time to attend to requests for termination given the targets now being set for prompt treatment of other conditions, eg a two-week wait for suspected cancer referrals. In addition, and uniquely in this particular form of secondary care intervention, there is statutory provision for physicians and other clinical staff to opt out of this work on grounds of conscience. For these reasons the local service remains overstretched and many women travel to Liverpool and further afield. The RCOG has attempted to address the issues by recommending a separate service for therapeutic abortion⁽⁸⁾: in Lancaster, this was formerly undertaken by the family planning service, now Community Gynaecology.

Surgical termination remains the mainstay of treatment in this area. However, with the recent addition of early medical termination, under seven week's gestation, surgery can be avoided. This offers patients who present early in an unplanned pregnancy the choice to 'miscarry' after two brief outpatient attendances. It is highly appropriate these patients are seen within community services, and there is good evidence that the specific targeted advice on contraception at the time of termination does increase subsequent uptake of a reliable method⁽⁹⁾.

Recent evidence also shows it is not the teenagers who have repeat terminations, but rather multiparous women from deprived backgrounds who have probably completed their family⁽¹⁰⁾.

Much effort has been put into intervention with these groups of women, with some financial backing from Neighbourhood Renewal and Sure Start.

Clearly there remains much health promotion to do as up to one third of women presenting for termination have used no method of contraception and alcohol plays its part with a predictable increase in referrals, every year 6-10 weeks after Christmas and New Year.

An outpatient vasectomy service is in the planning stage.

EXTENSION OF SERVICES

Much contraceptive advice is given by nursing staff, both in general practice and contraceptive clinics; straightforward cases are well-managed in this way. With appropriate training they are able to issue first-time and repeat hormonal contraceptives under Patient Group Directions. Emergency contraception is issued both by nursing staff and trained pharmacists, with medical backup by telephone. Both of these enable greater access by patients, but it has yet to be seen if this will be translated into increased overall uptake and lower unintended pregnancy rates. The uptake of emergency contraception has increased, and this may be extended shortly by school-based delivery by appropriately trained school nurses. This will also help to decrease the inequities in service provision seen in rural areas.

Young people represent an increasing proportion of our workload; their sexual health needs are great, their ability to use existing services low. Care is ideally holistic, with education taking place alongside sexual health advice and prescription of contraception. A large number of patients with Chlamydia positives are picked up and treated within the clinic set up in conjunction with Genito Urinary Medicine.

GOVERNMENT POLICY

Two documents, Sexual Health Strategy⁽¹¹⁾ and Teenage Pregnancy Report⁽¹²⁾ have impacted on community gynaecology.

The Sexual Health Strategy sets out the future of services both in general and specialist services. It concentrates on sexual infections with much less to say about contraceptive services and one line only on psychosexual counselling. The move towards integrated sexual health services provides more opportunities for young men to access services. Whilst we still have far less to offer young men in terms of contraception, their sexual health needs are just as great.

The much-vaunted male pill will extend the repertoire. It is based on an injected progestogen which prevents sperm production, with add-back testosterone, as the production of that hormone is also blocked.

The Teenage Pregnancy Strategy, however, has placed the onus not only on the Health Service but also local authorities and education services to reduce the United Kingdom's appalling rate of teenage pregnancy. The onus is on the PCT to mainstream some of these two-year initiatives. It is difficult to prove an effect on this timescale when government figures are only produced 18 months in arrears.

REFERENCES

1. Faculty of Family Planning and Reproductive Health Care, Clinical Effectiveness Unit. FFPRHC Guidance (October 2003). First prescription of combined oral contraception. *J Fam Plann Reprod Health Care* 2003;29(4):209-22
2. Harrison-Woolrych M, Hill R. Unintended pregnancies with the etonogestrel implant (Implanon): a case series from postmarketing experience in Australia. *Contraception* 2005;71(4):306-8
3. Beksinska ME, Smit JA, Kleinschmidt I, Farley TM, Mbatha F. Bone mineral density in women aged 40-49 years using depot-medroxyprogesterone acetate, norethisterone enanthate or combined oral contraceptives for contraception. *Contraception* 2005;71(3):170-5
4. Lara-Torre E, Edwards CP, Perlman S, Hertweck SP. Bone mineral density in adolescent females using depot medroxyprogesterone acetate. *J Pediatr Adolesc Gynecol* 2004;17(1):17-21
5. Penney G, Brechin S, de Souza A, *et al*; Faculty of Family Planning and Reproductive Health Care, Clinical Effectiveness Unit. FFPRHC Clinical Effectiveness Unit. FFPRHC Guidance (January 2004). The copper intrauterine device as long-term contraception. *J Fam Plann Reprod Health Care* 2004;30(1):29-41
6. RCOG. The Initial Management of Menorrhagia. RCOG Press; 1998
7. Reid P, Mukri F. Trends in hysterectomies performed in England for menorrhagia: examination of health episode statistics, 1989 to 2002-3. *Br Med J* 2005;330:938-9
8. RCOG. The Care of Women requesting Induced Abortion. RCOG Press; 2004
9. Yassin A, Cordwell D. Does dedicated pre-abortion counselling help to improve post-abortion contraception uptake? *J Fam Plann Reprod Health Care* 2005;31(2):115-6
10. St John H, Critchley H, Glasier A. Can we identify women at risk of more than one termination of pregnancy? *Contraception* 2005;71(1):31-4
11. National Strategy for Sexual Health and HIV. London: Department of Health; 2001
12. Teenage Pregnancy Report. London: Social Exclusion Unit; 1999