



## Dissent and resistance

**To the Editor:** I couldn't agree more with the sentiments expressed in your editorial entitled 'Medicine or politics?'.<sup>1</sup>

As a profession, knowing all the limitations of antiretroviral (ARV) therapy, perhaps we should devise for government a comprehensive management/treatment plan addressing *inter alia* the issue of 100% medication compliance in order to avoid resistance to ARV drugs. Thereafter we should proactively coerce government into considering treatment authorisation as is expressed repeatedly in the media.

Oops! To date I have not seen any mention in the press of the ease of resistance developing with medication default, the effect of class-specific resistance developing in such situations, and how best these issues could be addressed. We obviously have ample experience in the development of drug resistance to tuberculosis treatment because of poor compliance as a result of the high number of defaulters. Perhaps reference should be made to the consequent development of directly observed treatment (DOT). Yet tuberculosis medication is often defaulted on because of the side-effects of medication, which are miniscule in comparison with the side-effects of ARVs

Any comments?

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1. Van Niekerk JP, Medicine or politics? (Mini editorial) *S Afr Med J* 2002; 92: 657.

## IUCD insertion at caesarean section — a new look

**To the Editor:** The Mirena intra-uterine system was launched in South Africa in 1999. It has changed the way clinicians view the intrauterine contraceptive device (IUCD). Apart from the obvious contraceptive benefits<sup>1</sup> the device has many other advantages over the conventional copper IUCD.<sup>2</sup>

Immediate postpartum insertion of IUCDs has been undertaken in China since 1975.<sup>3</sup> Expulsion rates are lower with caesarean insertion compared with postpartum vaginal insertion.<sup>4</sup> Few complications were found in most studies and in a controlled trial comparing IUCD insertion at caesarean section with a non-intervention control, no difference was found in puerperal morbidity or infection.<sup>5</sup>

Following a presentation on Mirena at the South African Society of Obstetricians and Gynaecologists (SASOG) Sun City 2001 congress, the possibility of Mirena insertion at caesarean section was discussed with Dr David Horwell (UK expert) and certain possible clinical advantages may be postulated: (i) the progesterone release mimics the normal involuting puerperal environment of the uterus, which may decrease lochia and dysfunctional bleeding; (ii) after cessation of breast-feeding, the uterus will continue to behave as though the woman is breast-feeding, with persisting amenorrhoea or oligomenorrhoea for the 5 years of Mirena's licensed duration of use; (iii) the inert nature of the device makes intrauterine inflammatory response very unlikely and may therefore decrease the possibility of sepsis compared with a copper device; (iv) provision of long-term but reversible contraception, with effectiveness similar to that of female sterilisation;<sup>6</sup> and (v) the wider diameter and inert nature of the device may make expulsion less likely than with a conventional copper IUCD.

After the SASOG congress and after reviewing the literature, the author has commenced insertion of the Mirena IUCD at caesarean section. So far 4 patients have undergone placement of the device at the time of surgery, after full counselling. The device was inserted just before closure of the lower segment. A fundal insertion is obtained and the device is not sutured. Strings are cut at the level of the lower segment. Prophylactic antibiotics are given as a routine at surgery. To date all 4 patients have had no dysfunctional bleeding and are extremely satisfied. Although the device has not been removed after caesarean section no difficulty is usually found with removal with the threads cut short high in the cervical canal.

The author is happy to collate and arrange with interested practitioners an audit of 'The South African experience of Mirena insertion at caesarean section'. No such experience has been shared to date and I am sure our international colleagues would be keen to see the results from South Africa!

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2. Puzey M. The effects of the Mirena intra-uterine system on a private gynaecological practice. *O & G Forum* 2001; 4-6.
3. Xu JX, Connell C, Chi IC. Immediate postpartum intrauterine device insertion — a report on the Chinese experience. *Adv Contracept* 1992; 8: 281-290.
4. Chi IC, Ji G, Siemens AJ, Waszak CS. IUD insertion at caesarean section — the Chinese experience. *Adv Contracept* 1986; 2: 145-153.
5. Van Kets H, Thiery M, Van der Pas H. IUD insertion during caesarean section. *Adv Contracept* 1985; 1(4): 337-339.
6. Suvub I, Stern J, Coutinho E, et al. Prolonged intrauterine contraception: a seven year randomized study of the levonorgestrel 20 mcg/day and the copper T280 Ag IUDs. *Contraception* 1991; 44: 473-480.