The nulliparous patient, the IUD, and subsequent fertility

At the start of the rekindling of interest in intrauterine devices (IUDs) in the 1950s their use was generally confined to multiparous, older women, and nulliparous, younger women were usually advised to find an alternative means of contraception. Attempts were soon made, however, to design an IUD suitable for use by the young and childless woman. The accent was on finding a device which could be fitted without injuring the relatively tight cervical canal of the nulliparous woman. This problem has been reduced (but not entirely overcome) with the development of narrow-gauge IUD inserters, and the fitting of IUDs in nulliparous women has now become commonplace.

Nevertheless, the use of IUDs in this population has never been totally accepted, and recent publications have once again questioned its advisability. The cause for concern are not the problems associated with the fitting of the IUD—although these are not denied—but the longer-term consequences. These include a possible raised incidence of pregnancy, of expulsion of the device, and of bleeding or pain among nulliparous women when compared with parous women; a raised incidence of pelvic inflammatory disease; and the difficulties of administering an efficient IUD service among these women.1

After reviewing data collected from 20,000 IUD users in Britain Snowden et al.8 suggested that the IUD should not be the first choice for nulliparous patients, in whom the doctor should seriously consider alternative methods of contraception. They argued that (in addition to the points raised above) if a nulliparous woman abandons the use of an IUD owing to unacceptable side effects her experience may discourage her from trying it again when her family is complete—the time at which the IUD may be the most suitable contraceptive for many women.

The most serious doubt about the use of the IUD is that it may impair ability to conceive or complete a subsequent pregnancy. The evidence we have suggests that in most cases the ability to conceive after wearing an IUD is not unduly retarded;5 but the same cannot be said for women who have had pelvic infection, spontaneous abortion, or ectopic pregnancy.

The link between the use of the IUD and pelvic inflammatory disease is undoubtedly,6-8 but the problems of diagnosis and reporting have repeatedly thwarted attempts to establish the incidence with any accuracy. Despite these difficulties, Westrom et al.9 have shown that women wearing an IUD had a threefold increase in the rate of salpingitis when compared with other women and that, when controlled for parity, the increase among nulliparous IUD users was seven times that of nulliparous non-IUD users.

What makes these findings the more worrying is the apparent relation between pelvic infection and subsequent infertility.9 Furthermore, when pregnancy does occur the proportion who miscarry or who have an ectopic pregnancy is higher among IUD users than among non-IUD users.10-11 The effect of pelvic infection, spontaneous abortion, and ectopic pregnancy on the outcome of subsequent (possibly wanted) pregnancies is a matter of especial concern to those who are using an IUD as a means of delaying their first pregnancy.

At present we cannot categorically state that nulliparous women should discontinue the use of the IUD, but sufficient doubt has been raised to suggest the need for a prospective study designed to examine its effects in some detail—a call we made in 1976.12 Now, as then, we need a controlled prospective study among adequate numbers of nulliparous women—preferably including a substantial proportion (of both past users and non-users of IUDs) with a previous diagnosis of pelvic infection. If the main cause of illness among IUD users is associated with infection and if pelvic infection affects subsequent fertility, then such a study among nulliparous women is overdue.

6 Targum, S D, and Wright, N H, American Journal of Epidemiology, 1974, 100, 262.

Children’s Joint Committee

The report1 of the Committee on Child Health Services (the Court Report) was published in December 1976. It was widely discussed throughout 1977, but unfortunately most of the argument was concerned with the functions and status of various professional groups rather than with the need to improve services provided for children. The Government’s recommendations, which followed these discussions, were published in January 1978 and proved disappointing; for while the DHSS claimed to accept the overall philosophy of the Court Report it agreed to few of the specific measures that had been recommended. Perhaps the blame, if blame there is, should be widely shared. The Court Report was the outcome of a painstaking study of the history and current position of the child health services and provided an imaginative and far-reaching strategy to improve them—but it emphasised that the reorganisation it proposed might take 15-20 years.

Possibly the Court Report would not have aroused such a strong negative reaction among professional groups if its conclusions had concentrated more on principles and less on changes in status (general practitioner paediatricians, consultant community paediatricians, and child health visitors). The negative reactions were compounded by the chronic lack of finance and may explain the Government’s meagre response—but the fact remains that our child health services cannot match the exciting improvements in many other European countries.

One recommendation now implemented is the formation of a children’s joint committee. The Court Report stated, “It is our belief that children have special needs which they cannot articulate for themselves and that society has therefore a duty to ensure that these are identified and cogently represented.” It therefore recommended that a committee should be set up to give advice directly to the Secretary of State for Health and Social Services. To be effective such a committee needs to be small, with membership based on ability rather than representing sectional interests. These requirements are fulfilled by the composition of the new Children’s Joint Committee (the names of the members are given on p 288), which met for the first time on 6 July. It