An I.U.C.D. record card

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Despite the impact made by oral contraceptives on the problem of fertility control in the last decade, it soon became apparent that a considerable proportion of women were not suited by this method of contraception and in many cases traditional chemical and barrier methods proved to be aesthetically displeasing and too frequently fallible for sexually emancipated females. With the development of biologically inert plastics, however, interest was re-awakened in the intra-uterine device which, since the days of the Graefenburg ring, had fallen into some disrepute. A wide variety of types has been developed (Peel and Potts, 1969) but relatively few came to be generally accepted if the criteria of ease of insertion and low rates for expulsion, pregnancy and other complications were considered (Mills, 1970). The techniques of insertion were not difficult to learn (Frampton and Matthews, 1967) and the further development of devices individually packed and presterilised by gamma radiation led to increased general-practitioner use. (Hull, 1969; Peto and Peto, 1969; Orr and Terry, 1971; Webster, 1971).

Although few women in any one practice will use the IUCD, doctors undertaking insertions will want to record details about these patients to assess complication and failure rates and to compare results obtained with one device or another. Needle sorting of edge-punched cards provides a suitably simple method for analysis of such a relatively small series and, during the past five years, I have used this with plain 15·0 × 10·0 cm (6″ × 4″) Paramount Cards (Copeland-Chatterson Co. Ltd.) superimposed on a key template. The final design for a printed edge-punched card (figure 1) has been developed from experience gained from the analysis of about 150 insertions using this method.

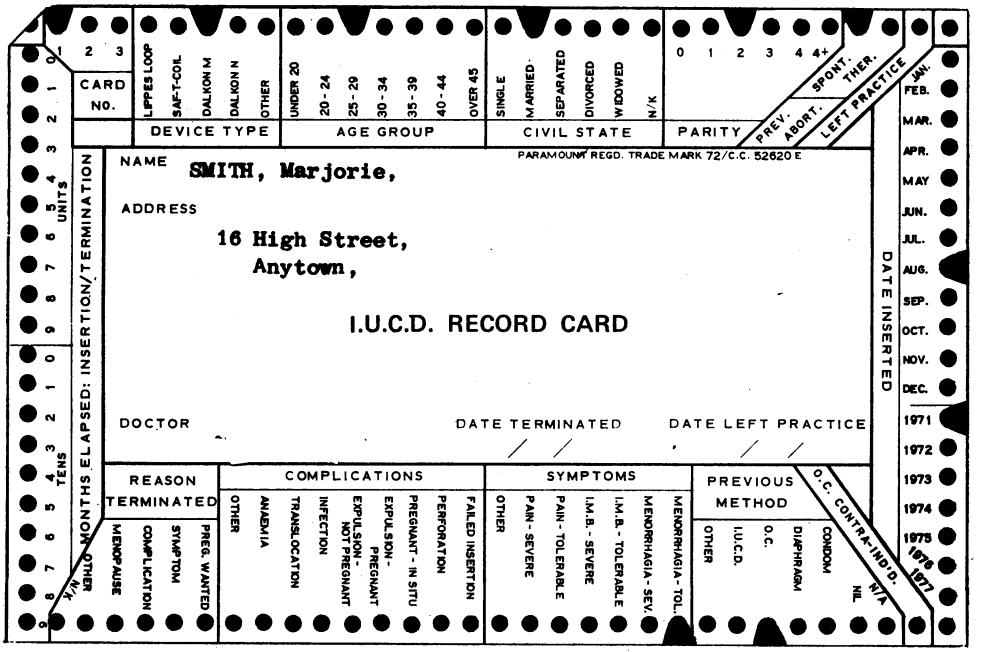

Figure 1. IUCD Record Card

Description of card

The card is arranged so that it can be punched in a logically progressive manner beginning in a

clockwise direction from the locator at the top left hand corner. The upper edge registers the patient's card serial number, device type and demographic information and the right-hand edge, the month and year of insertion. The lower edge records whether oral contraceptives are contra-indicated and also the previous method of contraception employed by the patient. Subsequent symptoms and complications associated with the device follow, with the final reason for termination of the insèrtion episode. The left-hand edge enumerates the number of months elapsed from insertion to termination or until follow-up fails. The reverse side of the card is reserved for notes and dates of follow-up examinations with a column for haemoglobin estimations.

Method

A new card is used for each insertion or attempted insertion. The patient's name and address are recorded and the card is punched appropriately as far as and including ' previous method '. Follow-up can be arranged at appropriate intervals, currently one, three, six and 12 months after insertion, and then annually. Symptoms should not be recorded by punching until at least six months have elapsed after insertion unless they are of such severity as to warrant the removal of the device. Thus, menorrhagia, intermenstrual bleeding and pain are regarded as ' tolerable ' if the patient is prepared to persevere with the method in spite of them; ' severe ' if the insertion has to be terminated.

With regard to complications, distinction should be made between a pregnancy occurring with a device *in situ* or following expulsion of the device. Likewise, ' perforation ' indicates penetration of the uterine wall at insertion whereas ' translocation ' signifies migration of the device subsequently. Other complications are self-explanatory and anaemia is arbitrarily taken to be a fall in haemoglobin level to below 10·0 grams/100ml.

After each insertion-episode or on the patient leaving the practice (' lost to follow-up ') the appropriate date should be entered on the face of the card and the number of complete months since insertion punched on the left-hand edge. If the device was removed, the reason for the termination should also be punched on the lower edge where appropriate.

Results

Assessment of failure and complication rates has been traditionally expressed in terms per hundred woman years (HWY) of exposure while employing a given contraceptive method. This may be most simply calculated by employing Pearl's formula (Pearl, 1932) which merely involves multiplying the number of pregnancies (or specific complications) occurring in the series by 1,200 and dividing the product by the aggregate number of months elapsed. Protection ratios and method continuation rates can be calculated by similar simple formulae (Peel and Potts, 1969), but all these indices are now generally regarded as giving an unreliable indication of device acceptability and performance, as failure and complication rates do not remain constant but decline with continuing use of the device. Moreover, the individual's natural fertility is another important variable.

To take these factors into account, a more accurate though more complicated method of assessment (the Life Table method) has been described by Potter (1966) and employed by Tietze (1967). This is now the internationally accepted definitive procedure for analysis of contraceptive effectiveness but it may be unnecessarily elaborate for use in general practice.

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