Letters

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Mirena® coil for heavy menstrual bleeding

In a recent editorial, Miriam Santer[1] highlights what little we know about quality of life and patient satisfaction following treatment for heavy menstrual bleeding. She points in particular to the paucity of relevant data comparing the levonorgestrel-releasing intrauterine system (LNG-IUS or Mirena®) with other medical treatments. Therefore, we agree that the recommended ranking in recent NICE guidelines,[2] suggesting Mirena coil as the first option for heavy menstrual bleeding, seems premature, may fail to account for patient preferences, and indeed lead to problems with concordance and therefore efficacy of treatment.

We are currently seeking to address some of this evidence gap in ECLIPSE, a large, randomised controlled trial assessing clinical effectiveness and cost-effectiveness of the LNG-IUS versus standard medical treatments for initial management of heavy menstrual bleeding in primary care and gynaecology settings (www.eclipse.bham.ac.uk). Outcomes include menorrhagia-specific and generic quality-of-life measures, and surgical interventions, with long-term follow-up at 2 and 5 years.

Unsurprisingly, we have found recruitment particularly challenging because many women have a strong personal preference for one form of treatment or another. Within, and alongside, the trial we are seeking qualitative data in order to understand women's experiences of treatments including those of women with strong treatment preferences. This investigation seeks to build on work examining social factors and influences on women's perceptions of heavy menstrual bleeding and perceptions of health professionals in this context.[3,4]

Thus, we aim to provide evidence not only on the long-term effectiveness and cost-effectiveness of medical treatments for heavy menstrual bleeding, but also to enhance understanding of receiving treatments from women's perspectives. As Santer notes, much further research is needed to promote a more holistic approach to women experiencing this common and complex condition.

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Author's response

It is welcome news that Gail Prileszky and colleagues are addressing the evidence gap for this common condition and are looking at patient preferences in their trial. The NICE guideline's ranking of levonorgestrel-releasing intrauterine system (LNG-IUS or Mirena®) above other treatments is indeed problematic in practice, where an emphasis on choice for the fully-informed patient seems more appropriate.

The NICE guideline is likely to benefit women in other ways, for instance in shifting the emphasis away from assessing volume of loss and towards assessing impact on quality of life. Unfortunately, the guideline only set out to address heavy menstrual bleeding and we know that other menstrual symptoms, mainly menstrual pain, increase the impact of heavy menstrual bleeding.[1,2] This is relevant to the difficulties with the ranking system. For instance, many women reporting heavy menstrual bleeding actually find menstrual pain more problematic, and for these women non-steroidal anti-inflammatory drugs (NSAIDs) might be a first-line rather than second-line treatment.

Prileszky and colleagues refer to the influence of social factors on women's perceptions of heavy menstrual bleeding. Social factors may influence their views of treatment as well. We found that women view heavy menstrual bleeding as 'not real illness', leading them to attempt to self care, including seeking information widely informally, and to consult only where self care has failed.[3] Women may therefore already hold strong views about different treatment options by the time they see a health professional.

Heavy menstrual bleeding is a condition which has long been in need of a stronger evidence base. Together, the randomised controlled trial and qualitative

findings from the ECLIPSE trial should enhance our ability to help women make the best choices about their health.

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nMRCGP exam

As I am now in my ST3 year and due to complete GP training next August, I am eligible to take my Clinical Skills Assessment (CSA). But when?

Having entered GP training at ST2, I completed 6 months in general practice and 6 months in an innovative post during my ST2 year. During ST3 I have 6 months of paediatrics, followed by 6 months of general practice. And there lies my dilemma.

I could sit the CSA in October or January/February, but at that time I'll be doing paediatrics. Although useful for my general practice career, not the best preparation for the CSA, as this will test a much wider area of practice.

Option 2 is to sit the CSA in May. I'll be back in general practice by this time so will have a chance to prepare properly for the assessment. However, results aren't published until June, just 2 months before I complete my training. I would therefore be applying for jobs without having completed my nMRCGP — would I even be eligible for short-listing? And if I don't pass ... My training programme complete but no nMRCGP. With the expense and time involved in taking the CSA, I don't want to just 'give it a go' in January without feeling properly prepared.

I am aware that other deaneries schedule the whole of ST3 in general practice, allowing trainees to choose from all three sittings of the CSA. Perhaps a sitting in mid-March for those of us doing a more restrictive training programme?

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Diabetes prevention

With the publication of several large randomised controlled lifestyle change trials showing benefit in delaying or preventing progression from pre-diabetes to type 2 diabetes, work has been taking place in many locations to translate research evidence into practical interventions to improve the care of our patients at the primary care level.

Laatikainen and colleagues are to be congratulated in conducting the large Diabetes Prevention Project in Australia.[1] Like us, they successfully delivered a structured programme to patients with pre-diabetes using group work, delivering education enhanced by motivational techniques. Our programme was a randomised controlled pilot study testing two different dietary interventions.[2] Theirs recruited a larger number of pre-diabetic participants and was able to show a statistically significant effect in reducing progression to type 2 diabetes compared with baseline using an audit methodology.

The biggest obstacle faced by many working in this field, including ourselves, is to secure adequate funding to develop and refine such pragmatic intervention programmes. This work is vital to the wellbeing of our patients. Up to 90% of people who develop diabetes may not have done so had their lifestyle choices been different, and interventions have been shown to make a real difference.[3] We congratulate our Australian colleagues on their excellent work and are also envious of the opportunities that they have for substantial translational research funding.

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In response to the article entitled 'Can type 2 diabetes be prevented in UK general practice?' published in the August issue of the *BJGP*,[1] we would like to highlight our experience with diabetes prevention.

In the Finnish Diabetes Prevention Study,[2] participants who successfully achieved their lifestyle-change goals for physical activity and diet did not go on to develop diabetes after 7 years of follow-up.[3] To determine whether the results of clinical trials could be reproduced in the 'real world' of primary care, the GOAL Lifestyle Implementation Trial to prevent Type 2 diabetes in primary health care,[4] a trial using a structured programme was designed and trialled in Finland.

In 2004–2006, a sister project of GOAL was run in the Greater Green Triangle region of South Australia: the Greater Green Triangle Diabetes Prevention Programme (GGT DPP). This study evaluated the feasibility of a structured group programme for lifestyle modification in Australian primary healthcare settings