FSRH Clinical Effectiveness Unit

The Faculty of Sexual & Reproductive Healthcare of the Royal College of Obstetricians & Gynaecologists

Intrauterine contraception: FSRH CEU Response to Public Consultation

The FSRH CEU would like to thank the individuals and representatives from our stakeholder organisations who have provided feedback.

Comments relating to typographic errors and format of the documents that have been addressed are not included in the response below.

Comments on recommendations and main body of text

Individual /organisation	Location in guideline	Comments	CEU's Response
Individual/ Peer Reviewer	General comment	Good, but very medicalized. Some of the methods of statistical analyses need to be explained so that people with less experience from research and statistics understand them better – for example Odds ratio and Relative Risk. There is a risk that the readers think they are the same. HR, OR, aHR, RR etc. A lot of abbreviations used here. Although these guidelines are for healthcare professionals, most readers will probably not understand them to their full extent. Just a thought - could the different type of ratios be explained in the beginning of the document, for axample after the list of abbreviations?	Unfortunately, explaining the different research terms used in studies is outside the scope of this guideline and it was felt it would make the guideline too long to explain this. However, the guideline has been split into sections so that the reader can still get the key clinical information without the need to read or understand the studies.
Individual/ Peer Reviewer	General comment	I also made a comment on not including too many statements based on non-existing evidence. That might lead to cementation of myths and misconception and fear of IUC provision.	Thank you, we have reviewed the text to ensure that where guidance is based on expert opinion due to a lack of evidence this is stated (in text and/or with evidence level grading)
Organisation	General comment	Excellent, though it was felt it could be useful to have all the key information transposed below the summary of recommendations as a 'longer summary' as it would make it easier for GPs to identify the information they are looking for.	This will be included in the final draft

Individual/ Peer Reviewer	General comment	The document presents things as trends, and indations stated as "may be higher", although evidence is limited. Is this by purpose, to kill misconceptions? I see a risk of presenting "truths" that not actually exists, which might lead to cementation of misconceptions.	Comment - wording amended to here to show that this is the GDG opinion, based on current practice.
Individual/ Peer Reviewer	3. Introduction	Consider adding that the new terminology “IUC” supersedes “IUS/IUD” and explain reasoning - this is presumably to align with terminology in international guidance Suggest adding a comment about WHO recommended nomenclature (https://www.who.int/publications/i/item/9789240021730) and introduce concept of hormonal and non-hormonal IUDs as in the future not all IUDs may be LNG/Cu. But then carry on to say ‘in this guideline we will use LND-IUD and Cu-IUD as these are products available in UK..etc’	Thank you, the terminology explanation has been added to the summary of changes. We have been specific in referring to Cu-IUDs and LNG-IUDs rather than ‘hormonal’ and ‘non hormonal’ for the very reason that other hormonal devices and other non-hormonal but non-copper devices may become available in the future and therefore the information in this guideline may not relate to them and these generic terms could cause confusion.
Individual/ Peer Reviewer	5. What is intrauterine contraception Clinical recommendations	Would it be useful to add a sentence about the different strengths of LNG -IUD available (13.5mg, 19.5mg, 52mg) and all are indicated for contraception? It could sit above the sentence about the 52mg LNG-IUD for additional indications?	Thank you for this suggestion, a KIP for this has been added.
Individual/ Peer Reviewer		***“A 52 mg LNG-IUD has additional potential gynaecological benefits, including management of heavy menstrual bleeding (HMB) and dysmenorrhoea.”*** The way this is worded could imply that ‘dysmenorrhoea’ is an approved indication. However, I cannot see it in any of the UK PIs. Is it better to reword as ‘additional non-contraceptive uses’ (for clarity and consistency with the heading on pg 14)	Thank you - changed to additional potential benefits
Individual/ Peer Reviewer		Should endometrial protection as part of HRT be mentioned here?	This is in the clinical recommendations

Organisation		Request footnote to clinical recommendations for 52mg LNG-IUD referring reader to table 2 for details of UK licensed indications for 52mg LNG-IUD products and /or a statement that guidance may differ from UK product licence	The wording in the KIP has been amended to avoid any confusion that 'indications' only referred to 'licensed indications'. The differences between licensed indications/durations and FSRH recommendations has been made in the text.
Individual/ Peer Reviewer		Is the MOA usually something that you include under 'Key information'? Not sure if it's the right place for that info.	The guideline development group considered that this was key information, as it is something discussed with individuals considering IUC use. Whilst MOA has not been included in KIPs in previous guidelines, the CEU plans to include MOA in future guideline KIPS
Individual/ Peer Reviewer		***"Any 52 mg LNG-IUD inserted at age <45 years can be used for contraception for 6 years."*** 8 years	In the UK, Levosert and Benilexa 52 mg LNG-IUDs are licensed for contraception for 6 years, Mirena 52 mg LNG-IUD for 5 years. The GDG recommends, however, that any 52 mg LNG-IUD inserted before age 45 years can be used for contraception for 6 years.
Individual/ Peer Reviewer		***"A Cu-IUD with copper surface area ≥300 mm^2 inserted at age ≥40 years can be used for contraception until menopause. It can be removed 1 year after the final menstrual period if this occurs after age 50 years."*** It would be helpful to clarify if a) this includes un-banded as well b) this applies to devices like mini-TT and Nova-T that are only licensed for 5 years	Wording changed from 'a' to 'any' for clarification. This recommendation is in line with established FSRH guidance
Individual/ Peer Reviewer	S5.1	***"...unprotected sexual intercourse (UPSI)..."*** There is a general move away from using "UPSI" in new BHIVA/BASHH guidance, as being on PREP, even without a condom, is classed as protected sex. "Condomless sex" is now the preferred term but you would have to go through the whole document! If that is too onerous, you could write a line at the beginning to explain that UPSI refers to condomless sex?	UPSI kept throughout document as when considering contraception (rather than infection) we are thinking about contraceptive protection and condoms are not the only type of protection we are referring to - eg could be using diaphragm, alternative hormonal contraception - so cannot change to 'condomless' in this instance
Individual/ Peer Reviewer		***"In addition to regular contraception, the Cu-IUD can be used for emergency contraception (EC), if inserted within 5 days after the first episode of unprotected sexual intercourse (UPSI) that cycle, or within 5 days***	The IUC guideline does not go into this level of detail but the link to the EC guideline is provided for further information

		of the earliest expected date of ovulation." ? change to say "in the last 21 days". There could be a patient for example with 35 day cycles, has UPSI on day 6 and then again on day 28 that would be eligible for an IUD if her PT is negative…	
Individual/ Peer Reviewer	S5.2	Change to guidance on using all 52mg LNG-IUDs as endometrial protection for 5 years and contraception for 6 years is extremely sensible and entirely welcome. Very helpful in clinical practice.	Thank you for your comment
Individual/ Peer Reviewer		The best bit as far as I'm concerned is the standardisation of all 52mg IUS devices. This will make it much easier to just stock Levosert and Benilexa in contraception clinics. We have a lot of women sent by their GP for Mirena fit and we don't do HRT coil fits. This will mean that we just fit the cheapest and there won't be quibbles. I'm not sure how the lack of IUC provision in GP practice can possibly manage the demand for HRT care as contraception services are not commissioned for that in our area but that is obviously outside of this guidance.	Thank you for your comment
Organisation	S5.3	It might have been helpful to include images of the different coils in the section where coil options are discussed, just to give trainees an idea of what they look like, and it might make is easier to retain information about each coil if it is associated with an image. It could perhaps be around pages 10 and 11 and images could fit into the table sections on those pages.	Although we agree this would be helpful, there were issues around ensuring these images were correct and updated, as well as copyright considerations and therefore it was not included.
Individual/ Peer Reviewer	Table 1	What about neosafe 380 mini? The mini version is now more in use as there is current manufacturing problem with mini-TT380 and can't get it	The table includes the IUDs listed in the BNF. Table header has been amended to clarify this.
Individual/ Peer Reviewer		"Novaplus T **380® Cu"** This one is on the Swedish market as well, but we have had several patients where we during extraction noticed a broken IUD. You might want to consider whether this should be on the list or not.	Thank you, the table is not a list of recommended IUDs, but instead includes those IUDs listed in the BNF. Table header has been amended to clarify this.

Individual/ Peer Reviewer		What about IUB?	The IUB is not currently available in the UK. A link to the information we currently have about IUB is provided on page 6. This will be updated if the IUB becomes available in the UK again
Individual/ Peer Reviewer	Table 2	Suggest order of these rows should be switched with licensed duration first and then recommended duration of use; Same for the "licensed for endometrial protection"	This was considered, but as a reference table it was felt that the recommended duration should come first as most clinicians will follow the recommendations, rather than the licensed durations.
Individual/ Peer Reviewer	S5.4	? add . "If the individual is under the age of 50, contraception may be stopped after 2 years of amenorrhoea."	We would not always suggest stopping contraception after 2 years, e.g. if the user was <40.
Individual/ Peer Reviewer		**"*The GDG recommends, however, that any 52 mg LNG-IUD inserted before age 45 years can be used for contraception for 6 years"*** Given that word on the street is that extension to the Mirena license to 8 years is imminent…would it be clearer to rephrase this to: "any 52 mg LNG-IUD inserted before age 45 years can be used for contraception for 6 years (or for its licensed duration, if this is longer than 6 years)."	If any changes to licensed duration occur (for any of the devices), the guideline will be amended at that time to prevent any confusion.
Individual/ Peer Reviewer		***"The COVID-19 pandemic prompted renewed discussion regarding extended use of LNG-IUD devices beyond their licensed durations."*** In the USA, mirena has been licensed for 7y since Aug 2021 and now Levosert for 8y since Nov 2022 - has evidence used to obtain that be reviewed? Also, old (prior to 2015) FSRH CEU guidance stated that 52mg LNG-IUDs/IUSs could be replaced if <7y from insertion, PT neg, no UPSI in the previous 7days but repeat PT after 3weeks - what evidence supported this advice then? would it be reasonable to update this advice accordingly to if <8y from 52mg IUS insertion?	Yes, the study this change was based on is included in this paragraph - reference 12. In the UK, at the time of guideline publication, the MHRA has not approved this. This was considered by the GDG and felt that no change was appropriate based on current available evidence
Individual/ Peer Reviewer	S5.5.1	***"Mirena is also licensed for use for endometrial protection as part of hormone replacement therapy (HRT)."*** Please read in conjunction with the previous comment	This was considered, however it was felt that the current wording made clear the differences in licensed durations and recommended durations and amendments may make the information less clear.

		box to avoid perception of the writer having a preference for mirena ie Suggest amend so that it is written in the same manner as the bottom paragraph on page 11, to avoid the risk of subconsciously putting mirena in a more positive light than the others. Perhaps delete the word “also” The word “also” might imply that there are more positive aspects of mirena being highlighted more here eg. mirena is “also licensed for endometrial protection” and although mirena is “the only one” licensed for endometrial protection” . If you are keeping this, you would have to add to the bottom paragraph on page 11 (previous page) that Levosert/Benhilexa are “the only ones” licensed in the UK for 6 years for example.	
Individual/ Peer Reviewer	P12, S5.5.3	***“The 52 mg LNG-IUD is a recommended treatment option for pain associated with endometriosis in individuals who are not trying to conceive”*** Is there any evidence of lower dose IUS being helpful? If only to say that there are no studies or unknown?	No studies were identified, a sentence has been added to confirm this
Individual/ Peer Reviewer	S5.6	***“Progestogenic effects on cervical mucus prevent the passage of sperm into the upper reproductive tract, whilst the effect on the endometrium may inhibit implantation. In some individuals the LNG-IUD will also inhibit ovulation. A foreign body effect may also contribute, as has been observed with other intrauterine methods.”*** Consider reading papers in full, which show that endometrial tissue analyses have unfortunately been used as surrogates for contraceptive effect. on the otherhand, demonstration of inhibition of transport of both gametes/conceptus by progestogenic effects on cervical mucus has been proven and seen with the higher rates of ectopic pregnancies with LNG-IUDs.	Thank you, this section has been reworded
Individual/ Peer Reviewer	S6.1	Should we add – “There are no licensed framed Cu-IUDs with copper surface area <300mm^2 – at the time of guideline publication” ?	Thank you - added

Individual/ Peer Reviewer		Consider a section after LNG-IUS (e.g. 6.3) that compares Cu-IUD/LNG-IUD efficacy and details the evidence of paragraphs 2,3,and 4 there - the paragraph seem out of place here	We have moved this as suggested
Individual/ Peer Reviewer		***"However, as an observational study there may be confounding relating to the types of Cu-IUD that were recommended to and selected by individuals and the availability of data did vary significantly between devices, for instance only 92 frameless device users were included compared to over 4000 T-shaped device users."*** Which should be the case as the T-shaped IUDs are the ones with longer duration and should be the IUDs recommended by the HCPs. I suggest remove this paragraph, or focus on the significant findings - type off devices led to more bleeding, pain, expulsion, etc.	This information is included in order to describe all the available evidence
Individual/ Peer Reviewer		Do we need to explain what the Pearl Index is for non-specialists?	This has now been added
Individual/ Peer Reviewer		***"... transgender and gender-diverse individuals assigned female at birth (TGD-AFB)."*** May be easier to read if not abbreviated. It is only used 3-4 times, so consider writing out in full	This was considered, but it was felt that the abbreviation made it easier to read and was therefore kept.
Individual/ Peer Reviewer		I would change this "topical" to "local vaginal" as in my experience a lot of clinicians interpret topical as meaning transdermal.	Thank you - changed
Individual/ Peer Reviewer	7.1.3.1	***"There is very limited evidence on insertion of Cu-IUDs 3–4 weeks after childbirth, therefore the insertion of Cu-IUD for EC between 3 and 4 weeks should be based on clinical judgement"*** Whilst I know there is no evidence on this, it would be very helpful to have included some expert opinion on what and how significant the potential/theoretical risks would be for fitting a coil in this scenario. This would be helpful to guide clinical judgement and client counselling in the rare cases where this is contemplated (e.g.for EC coils from 21-28 days postpartum.)	It is established practice and long-standing UKMEC guidance that unless IUC is inserted within 48 hours after childbirth, insertion should usually be delayed until 28 days after childbirth. Therefore there is very limited evidence or clinical experience in this area. Suggestions for what should be considered have now been included to aid decision making

Individual/ Peer Reviewer		***"Similar results have been seen in other studies. Another large, prospective cohort study[113] of 22,795 IUC users identified 30 cases of perforation. Of these, 87% (26/30) of perforations"*** Suggestion - add the risk of perforation in percentage of the cases "...yielding an absolute risk of perforation at 0.013%". This to calm down anxious providers.	This was not added here as the risk of perforation quoted (1.3 per 1000) was the overall risk of perforation in this study and not the risk relating to postpartum insertion, as is being discussed in this section. However, we do have the overall risk of perforation included in the perforation section.
Individual/ Peer Reviewer		***"Despite an increased rate of expulsion, immediate postpartum IUC insertion is associated with high continuation rates, with many individuals opting for reinsertion if expulsion occurs. The aforementioned Cochrane review found IUC method continuation at 6 months was higher in those who had immediate postpartum insertion compared to interval insertion (81% vs 67%; OR 2.04, 95% CI 1.01–4.09)."***	This recommendation has been added and a link to the PPIUC pathway included

Individual/ Peer Reviewer	S7.1.3.2	***"Methods of excluding an ongoing pregnancy prior to the resumption of menses include either a negative low sensitivity urinary pregnancy test at least 2 weeks after misoprostol administration or ultrasound examination."*** It would be good to add here that a good clinical history can be used to exclude continuing pregnancy. This history would cover- bleeding with clots after abortion medication; pregnancy symptoms have subsided; no sign of infection, no signs of RPOC **"*If successful expulsion has not been confirmed (e.g. individuals who pass the pregnancy at home), exclusion of ongoing pregnancy is necessary before insertion of IUC [102]. Methods of excluding an ongoing pregnancy prior to the resumption of menses include either a negative low sensitivity urinary pregnancy test at least 2 weeks after misoprostol administration or ultrasound examination*"** I have heard of some practitioners proposing to fit coils post MTOP on the basis of the client giving a good history of bleeding and clots as confirmation that the pregnancy has been expelled. Could you make it clear whether you would support this practice? As the guideline is currently phrased it seems to indicate that either a neg preg test or a USS is required, however using "Methods of excluding an ongoing pregnancy prior to the resumption of menses **include….** (my emphasis)" leaves it open to interpretation whether other 'methods of excluding pregnancy' are acceptable as well. I see that you refer solely to the FSRH guidance on IUC after pregnancy here. Are there any new articles published? We have recently published on "immediate" insertion (within 48 hours of pregnancy expulsion) after medical abortion, in which we did not awaited confirmation of completed abortion prior to insertion, instead the confirmation was by urine test 2-4 weeks later either at home or in the clinic. doi: 10.1016/j.ajog.2022.07.063.	Thank you for this feedback – the section has been reworded to allow for local variations in protocol Established FSRH guidance is that for individuals in whom successful expulsion has not been confirmed (e.g. those who pass the pregnancy at home), exclusion of an ongoing pregnancy is necessary prior to IUC insertion. Methods of excluding an ongoing pregnancy prior to the resumption of menses include either a negative low-sensitivity urinary pregnancy test at least 2 weeks after misoprostol administration or ultrasound examination at any time after the medical abortion. Since the development of the Contraception After Pregnancy guideline, uptake and availability of early medical abortion (EMA) has increased. New evidence from studies of EMA will be reviewed by the relevant expert panel when the Contraception After Pregnancy guideline is updated and any changes to this recommendation will be updated in this guideline. In the meantime, although FSRH guidance continues to be that ongoing pregnancy needs to be excluded by pregnancy test, ultrasound scan, examination of pregnancy tissue passed by an HCP or resumption of menses, local protocols that reflect the most up-to-date evidence may vary, and clinicians may follow alternative, evidence-based local pathways and protocols.

Individual/ Peer Reviewer	P24, S7.1.3.3	***"IUC should not be inserted in the presence of sepsis after miscarriage or ectopic pregnancy [89,102] or where there is any possibility of an ongoing pregnancy."*** Maybe add "current" ectopic pregnancy to reinforce that PMH ectopic is not a contraindication	This has been left as it was as the point relates to current sepsis (as a result of ectopic pregnancy) rather than current ectopic pregnancy
Individual/ Peer Reviewer	S7.1.4	Regarding the section on perimenopause and bleeding where it is stated 'although many individuals will not need investigation prior to *IUC* insertion…' there were a few comments. Regarding investigations, it was felt that the wording on the need to investigate irregular menses needed strengthening in order to avoid missing endometrial cancer. Later in the document it is clear that menses irregularities associated with LNG-IUD can occur and if there are no reasons to suspect endometrial cancer initially, it can be classed as DUB. However, endometrial cancer could be missed and it was felt the wording could be more direct to avoid missing this important diagnosis.	Wording amended to be more direct
Individual/ Peer Reviewer	S7.1.7	General comment to the paragraph on distortion: I miss guidance to practitioners in outpatient clinics, i.e. midwives or other inserters: When should we suspect uterine malformation and not proceed with the insertion. For example, "if unable to pass the inner os of the cervix, and when sounding measures falls below the recommended measures, abort the insertion and refer to a clinic with specialist competence for further care"	Sentence added for further guidance: " If examination findings suggest there could be uterine malformation or cavity distortion, clinicians should consider delaying IUC insertion and arranging an USS to assess the uterus."
Individual/ Peer Reviewer		"Although the authors report no complications in these three cases, the individuals were only followed up for less than one year." I think its better to write for how long they were followed	Unfortunately one study does not report the timeframe but suggests no/very short follow-up, the other was for 9 months. Sentence has been amended
Individual/ Peer Reviewer	S7.1.8	***"...triple stripe endometrium..."*** Not sure everyone would know what "triple stripe" is, unless a sonographer or gynaecologist.	Rewritten to clarify

Individual/ Peer Reviewer	S7.1.9	Can we suggest something pragmatic eg. “Usually after at least x weeks”? if only based on expert opinion	Added
Individual/ Peer Reviewer		When is immediate insertion not appropriate? Should this be stated in the guideline	There is not robust evidence to inform outcomes following immediate reinsertion vs delayed and the GDG are therefore unable to comment on this – it will be down to the colposcopist discretion/local guidelines. The wording in the evidence section has been amended to clarify that the decision would be made by the person carrying out the LLETZ.
Individual/ Peer Reviewer	7.1.10	Is it worth making explicit the situation re : **asymptomatic** GC – still UKMEC 4??	Amended
Individual/ Peer Reviewer	Table 10	The separation of UKMEK categories in I and C has not been used in previous tables. I see no information on what I and C stands for here, but suppose they stand for Initiation and Continuation? Could you clarify that somehow in the table legend?	This is now in the table legend
Individual/ Peer Reviewer		Does “other STI’s” this include mycoplasma?	Thank you for raising this. UKMEC 2016 was written before testing and treatment of MG became widespread. As there is a lack of evidence for IUC insertion in individuals with MG, and expert opinion differs, we have been unable to make a recommendation but have added information in the text to explain this. This will be looked at during the development of the updated UKMEC where an expert consensus will be made to aid decision making.
Individual/ Peer Reviewer		***“Routine STI screening of asymptomatic individuals requesting IUC is not necessary; however, a sexual history should be taken prior to IUC insertion and screening offered - particularly if factors associated with increased risk of STI are identified.”*** “At risk” is difficult to interpret and may need some elaboration. Maybe a pragmatic approach especially in general practice where they might presume that you are not high risk because you are married eg. If in a long-term relationship, you could ask “when did you last have sex with a different partner?” to give you a better idea of risk	Elaborating on this would be outside the scope of this guidance, however we have reworded the text and linked to BASHH guidance to aid decision making

Individual/ Peer Reviewer	S7.1.10.2	If bacterial vaginosis , **trichomonas vaginalis** or candida infection is diagnosed or suspected	Added
Individual/ Peer Reviewer	S7.1.11	"In addition, an included prospective cohort study (n = 150 HIV-positive individuals) had its results stratified by CD4 count and found no difference between severely, moderately or mildly immunocompromised individuals **(no definition provided)**." Many HIV services no longer monitor CD4 count anymore once on effective treatment with a sustained undetectable viral load. Is there any evidence looking at infection rates stratified by viral load rather than CD4?	This is a really pertinent point but unfortunately the (limited) available literature does not stratify by viral load so we are unable to make any recommendations based on VL results
Individual/ Peer Reviewer	S7.1.12	***"...especially those on an oral prednisolone dose of <10mg/day"*** - Should this read instead: more than 10mg/day?	Those who are on a low dose of prednisolone are more likely to need an increased dose. See endocrine society sick day rules
Individual/ Peer Reviewer	S7.1.13	"Some types of Ehlers–Danlos syndrome (EDS) are associated with an increased risk of uterine rupture **in pregnancy** and/or joint hyperlaxity."	Amended
Individual/ Peer Reviewer	S7.1.14	***"as well as ensuring availability of haemostatic agents/equipment, in line with the algorithm in Figure 1."*** Figure 1 refers to silver nitrate/stitches. Does this sentence then imply that coils should only be fitted when access to all of these are available (i.e. a practitioner trained in putting in stitches, etc)? Or would access to silver nitrate alone be sufficient? Or are silver nitrate and stitches both 'nice to have available ' rather than 'must have available ' in these scenarios?	Thank you for picking up that we should have removed stitch from figure 1, which was taken from the guideline "FSRH CEU Statement: Management of women taking anticoagulants or antiplatelet medications who request intrauterine contraception or subdermal implants (March 2017) " and relates to implant insertions, not IUC insertions
Individual/ Peer Reviewer	S7.1.14.1	Just a comment: Not sure in what scenario the STI could not be treated prior to insertion, or at least on the day, yet the suitability of the IUC could be discussed and endocarditis prophylaxis could be started prior to insertion?	Agree this scenario would be unlikely, however it was recommended by the cardiologist and may be useful to have in place to remind people to discuss with the cardiologist. For example, if an individual required an IUD for EC, a telephone call to their cardiologist to see whether or not they felt that antibiotic cover as prophylaxis against endocarditis would be warranted alongside the empirical treatment of the presumed infection (as the genital infection would not immediately resolve as soon as the antibiotics were given and the two things may require different antibiotics)

Individual/ Peer Reviewer	S7.1.16	Is there any difference between brands of copper IUD with regard to the purity of the copper component? Is there a manufacturing standard for purity or do any manufacturers have information about levels of purity in their product? I do seem to see some people very keen for an IUD but seem to have a bad reaction who are people with sensitivity to non-precious metal jewellery. If there was a certain IUD brand that contained purer copper than others it would be very helpful to know.	Unfortunately this information is not available and there is not evidence that any device is associated with better outcomes than any other in this regard
Individual/ Peer Reviewer	Table 11 and 12	Could we have these definitions in a box like we have with the implant guidance on page 17 Also re Irregular: 3-5 bleeding/spotting episodes and **<3** bleeding/spotting free intervals of 14 days or more during a 90-day reference period should this be **less than** 3 bleeding free intervals or **more than** 3 ??	Table of definitions added WHO criteria is 3-5 bleeding/spotting episodes and **<3** bleeding/spotting free intervals of 14 days or more during a 90-day reference period
Individual/ Peer Reviewer	Table 15 and 16	Suggest delete these tables and instead direct readers to FSRH switching guidance to avoid risk of contradictory guidance if the switching guide gets updated.	This is a helpful suggestion, however the switching document is only available to FSRH members
Individual/ Peer Reviewer	Table 15	***"(outside terms of product licence after Day 7)"*** - to make consistent with advice on row 6	As the tables are designed as a quick reference guide, we do not usually explain where it is inside or outside of product licence (this is in the text of the guideline), but this was accidently added in row 6. We have now removed this.
Individual/ Peer Reviewer		Would this apply if their menstrual cycle was short e.g. 21days? if not, may be worth specifying accordingly in a footnote e.g. 'for menstrual cycles 28 days or longer'.	The SPCs do not differ depending on cycle length, however we have decided to amend this to say 5 days, in keeping with previous switching guidance, and to err on the side of caution where individuals may have a short cycle.
Individual/ Peer Reviewer		Under 'Additional contraceptive precaution required', it states 'Yes, for 7 days (unless inserted in the first 7 days of the menstrual cycle)'. However, on the previous page (pg 59), it mentions that you can be reasonably certain an individual isn't pregnant if it's within the first 5 days of a normal menstrual period.	It was initially a deliberate change, however after consideration we have decided to change this. The SPC for the LNG-IUD says it can be fitted up to day 7. However we have decided to amend this to say 5 days, in keeping with previous switching guidance, and to err on

		Also, it differs from what is recommended in your 'Switching or Starting Methods of Contraception' guidance (on pg 4), which says Day 1-5 of natural cycle. Was that a deliberate decision to differ from the 'Switching or Starting Methods of Contraception' guidance?	the side of caution where individuals may have a short cycle.
Individual/ Peer Reviewer		In the FSRH EC guidance, it states viable sperm are present in the upper genital tract for only about 5 days after UPSI. Please clarify rationale for 7	It is established practice that IUC is retained for 7 days after UPSI prior to removal. With this practice, we do not see resulting pregnancies. While sperm will no longer be viable after 5 days, there may already be a fertilized egg/blastocyst present thus risk of pregnancy is determined not only by sperm viability but also by ability of a blastocyst to implant
Individual/ Peer Reviewer		? add – "or malpositioned IUS > 2cm from fundus"	This was considered but as it is included in the text it was felt it was not a key point for the table, which we are trying to keep as succinct as possible for ease of use
Individual/ Peer Reviewer		? add " outside terms of product license less than 6 weeks after childbirth"	As the tables are designed as a quick reference guide, we do not usually explain where it is inside or outside of product licence (this is in the text of the guideline), but this was accidently added in row 6. We have now removed this.
Individual/ Peer Reviewer		I realize this is the advice given in the old IUC guideline but can we make consistent with implant guidance which says **day 5**	The SPC for the LNG-IUD says it can be fitted up to day 7. However we have decided to amend this to say 5 days, in keeping with previous switching guidance and contraception after pregnancy guidance
Individual/ Peer Reviewer		I think we need to be specific and say POP – **norethisterone, levonorgestrel** or desogestrel "Traditional " is almost as meaningless as "generations" of CHC to the non-specialist	Thank you this was an interesting point that we did discuss. However, we have not used NET/LNG as in the future (or in other countries) there may be other NET or LNG pills with different doses or other formulations of LNG and NET that are not contraceptive. The NET/LNG POPs have continued to be called 'traditional' in FSRH guidance because they work in a specific way, with specific missed pill/starting/switching guidance that is different to the desogestrel and drospirenone pills but the same as each other. This is not the same with the different pill generations.

Individual/ Peer Reviewer		Use consistent language throughout so should be same as first row: Ideally abstain/use condoms for 7 days prior to change in case new device can't be inserted	Initially did not say 'ideally' in case there was any confusion and the reader at quick glance thought the 'ideally' also applied to PT etc. Has now been amended to clarify that the ideally bit is only relevant to the abstaining PRIOR
Individual/ Peer Reviewer	Box 2	This is helpful and I can see myself incorporating this checklist into my clinical notes when inserting IUDs but I think the final bullet point can be deleted ('appropriate equipment available') as should be self-evident if procedure completed successfully.	This last item has been kept, as the checklist was designed to aid pre-insertion information and preparation, rather than the procedure itself. The title of this box has been amended to clarify this
Individual/ Peer Reviewer	S10.4.3	***"This assistant should be an appropriately trained healthcare professional".*** Healthcare **professional** sounds like this should be a doctor or nurse or someone with a professional registration. In practice the assistant is more commonly a healthcare assistant, technician, or similar. Could this be reworded or be more explicit about the requirement?	'healthcare professional' removed.
Individual/ Peer Reviewer	S10.5.1	***"Pelvic ultrasound pre-, intra- or post-procedure is not routinely required. However, for complex IUC procedures, ultrasound examination prior to or during the insertion procedure may be useful."*** On the recent USS theory course, it was highlighted that there should be some standards/expectations set by the FSRH for what should be examined and reported when a focused USS scan pre or post IUD procedure is done. For example, since there is no indication for examining the ovaries in a post procedure scan solely to confirm IUD position, would it be appropriate to not examine them and document "Ovaries not examined"? It would perhaps be a good opportunity to set some standards/ expectations for focussed USS examinations in this paragraph?	This falls outside of the scope of CEU clinical guidance but has been forwarded to the clinical standards team for consideration
Individual/ Peer Reviewer	S10.6	I am disappointed there is no mention of the use of Entonox (or even Penthrax) for insertions. It's licensed for painful procedures anyway and really helps to mitigate anxiety about pain especially amongst young	Nitrous oxide *was* included in the papers used in the original version but this section has now been expanded - see 'oral analgesics and other' section

		women or those who have had a previous bad experience. Feedback and VAS suggest it really helps too	
Individual/ Peer Reviewer		Could a statement/point of clarification be added that anaesthesia can be offered in GP settings (provided appropriate equipment/support/storage etc available) and patient request/need for anaesthetic shouldn't necessarily lead to referral to specialist services (aware of this happening in some areas)	Text clarified
Individual/ Peer Reviewer		There is no mention here of xylocaine spray here and yet the FSRH has a video on how to use it. Is this an oversight?	Xylocaine is a brand name of 10% lidocaine spray
Individual/ Peer Reviewer		Why are we using trade name EMLA for cream but not for the other preparations (eg Xylocaine®)?	Changed and brand name removed
Individual/ Peer Reviewer		***"Some evidence of benefit from 2.5% lidocaine plus 2.5% prilocaine cream applied..."*** In the key points I think you refer to this as Emla cream, please add the word Emla here too for clarity	It was noted that brand name was used for Emla but not the other anaesthetics, therefore in the key points the word Emla has been removed and 2.5% lidocaine plus 2.5% prilocaine cream used instead
Individual/ Peer Reviewer		***"One RCT reported a much higher rate of vaginal irritation in the lidocaine spray group than in the placebo group (lidocaine: 34 (54.8%) vs. placebo: 1 (1.6%), p<0.001) [270]. Excess spray may be wiped away after application to try to reduce risk of vaginal irritation."*** Please consider recommending, as a result of this observation, that clinicians wipe the cervix and vagina dry after lidocaine spray use. This is the practice of services that routinely use lidocaine spray. The sentence before this could be moved to after this one highlighted, and the recommendation added to that.	Added
Individual/ Peer Reviewer		***"Naproxen 550 mg was associated with a reduction in VAS pain score at 5 and 15 minutes after placement in one study, but these differences (9 and 11.2 mm, respectively) would not typically be regarded as clinically significant."*** this has highlighted, and is in line with advice from pain	There was insufficient evidence to recommend a specific time point for the administration of oral anlgesia. Removing the NO study as not relevant re timing, the other studies in the GD2019 review were ■ Ibuprofen given 30-45min in advance (they acknowledge it may take up to 2h for max effect, but note that the benefit likely begins at 30min and thats a more practical

		specialists, that oral analgesics need to be administered or used at least 1.5hours prior to procedures to allow for effectiveness.	timeframe if given onsite) ■ Naproxen given 60-90min in advance (for the reason that analgesia starts at 30min and peaks at 1-2h) ■ Ibuprofen 1h in advance (no discussion of timing) ■ Ketorolac 40-60min in advance (as the review flags the authors note that ketorolac may take 1-2h for peak effect) ■ Naproxen 45min prior
Individual/ Peer Reviewer		Can you comment on paracetamol please, if only to say no evidence?	Comment on paracetamol added (unfortunately no evidence)
Individual/ Peer Reviewer		However, the trials included involved only multiparous individuals and were conducted **30–40** years ago, since when devices, inserters and insertion techniques have evolved. Could be deleted?	Considered but kept
Individual/ Peer Reviewer		***"The evidence base on insertion pain for novel IUC devices, such as the intrauterine ball, is currently very weak due to a lack of robust data."*** It would be useful to expand more on exactly why the evidence is weak as more and more people are asking about it. Please elaborate / expand this section.	At time of writing there are only 4 published studies on IUB and it is not available in the UK, therefore we have only included very limited information in this guideline but have included (in the types of IUD section) a link to the IUB statement which is a live document that we will continue to update if more studies are published.
Organisation	S12	Communication with primary care is essential by all services to support onward care. It is common for patients to have a lack of knowledge of their IUC when consulting with primary care They are often unsure when their Cu-IUCD or LNG-IUD was fitted and the duration of protection they have e.g. 5 or 10 year coil, which can make planning difficult, especially for those who want to change it's use to be part of HRT at an undefined period after their fitting. Can we please add to the document a section on communication with primary care ensuring a record/ documentation is shared to include when the device was fitted, the type of device and when it is due to be changed	This has been added in the documentation section

Individual/ Peer Reviewer	S13	Nothing about vibrating gym plates in new guidance… are they no longer used or is there no evidence to support any recommendation?	There were so many things from the scoping exercise that users wanted included in the guideline, but this was not one of them and so it was removed to make room for other things that may be more relevant/common. We have no specific evidence on this
Individual/ Peer Reviewer	S13.2	?consider adding good practice point to give the patient a preg test to do at hom, rather than bringing them back to clinic or asking them to buy one	This would be down to local protocols, so cannot be a recommendation within the guideline
Individual/ Peer Reviewer	S13.3	As per my earlier comment, I prefer “condomless sex” (as used here!) rather than UPSI for the reasons mentioned already. The guidance needs to use one.	In this guideline we have to consider protection against pregnancy as well as condom use. This is a very specific situation where there is likely to be an IUC in situ, thus sex is not ’unprotected’ from a contraception point of view. They key point for this particular scenario is that there is no condom, however elsewhere in the guideline the key information is whether or nt there is any protection against pregnancy, hence ‘UPSI’ used.. We agree that in future an alternative term to reflect sex that has taken place in the absence of contraception would probably be helpful but this would be different to condomless sex.
Individual/ Peer Reviewer	S13.5	Is there any evidence at all for avoiding tampons for the first few weeks? If not, can the guideline group consider writing that tampons etc can be used with immediate effect?	We don’t have evidence to say this but have reworded this section to make clearer what we do and do not know.
Individual/ Peer Reviewer		This section is missing out up to 24 months post insertion data obtained from an RCT: Long, J. et al Menstrual Cup Use and Intrauterine Device Expulsion in a Copper Intrauterine Device Contraceptive Efficacy Trial [OP01-1B]. Obstetrics & Gynecology: May 2020 - Volume 135 - Issue - p 1S doi: 10.1097/01.AOG.0000662872.89062.83	Thank you for highlighting this conference abstract, which has now been included.
Individual/ Peer Reviewer	S14.1	Although not within the scope of this guidance to go into details, it would be helpful to add link/signpost to a guideline that says ok to continue add on COC indefinitely if it helps in this scenario if no contraindications. This is a common query.	Unfortunately there is no guideline that says this that we can link to.

Individual/ Peer Reviewer	S14.3	***"Clinicians should explain to individuals who have an intrauterine pregnancy with an IUC in situ that the risk of adverse pregnancy outcomes (including miscarriage, preterm delivery and septic abortion) is greater than that for pregnancies without an IUC in situ"*** This statement is unfortunately inaccurate to some degree, and it will be good for the CEU to avoid it. Overall ectopic pregnancy risk is lower with IUC versus no contraception, and lower with the IUD compared to the IUS or condom use e.g. see figure 1 here https://bjgp.org/content/69/679/98.full	It is included in the text that ectopic risk is lower with IUC vs no contraception. Information from the Contraceptive Choice sub-analysis (ref used for table 1) has now been included in the evidence section, thank you for this suggestion
		Also, NICE guidance recommends quoting to patients that their risk of ectopic pregnancy with IUC is 1 in 1000?	This is from a NICE CKS and there is no reference given for their figure. From studies, the rates of ectopic pregnancy quoted vary widely and therefore we have not included this figure.
Individual/ Peer Reviewer		This states that removal is associated with increased risk of miscarriage and this is repeat in text below, but no citation supplied. In studies in systematic review https://doi.org/10.1016/j.contraception.2011.06.010 miscarriage rate following removal was approx. 20% where recorded, which is broadly similar to background rate of miscarriage in first trimester (Tommy's Charity reported estimates). Suggest either adding in citation for statement or modifying statement to say 'the risk of miscarriage following removal is similar to the background rate of miscarriage but could improve later pregnancy outcomes'.	Thank you for noting this. This section has now been revised.
Individual/ Peer Reviewer		Please add rationale for clarity re don't remove after 12 weeks, is there a greater risk of miscarriage if taken out after 12 weeks?	This is due to a lack of evidence in outcomes at this gestation. The text and evidence section have now been updated to make this clearer.
Individual/ Peer Reviewer	14.4	Add that microbiological confirmation required ie not diagnosed on the basis of self-report, as many do not have BV or thrush	This has been addressed in main text. It is important to recognize that if someone has symptoms that they feel are made worse by their IUC then they can opt to have IUC removed whether or not diagnosis/infection is confirmed.

Individual/ Peer Reviewer		? add and if no other risk factors re BV/thrush identified	As above. Link to BASHH guidelines now in main text to signpost reader to risk factors.
Individual/ Peer Reviewer		? highlight here that even if STI screen taken on the day of the procedure, can proceed with insertion as long as asymptomatic and the patient is happy	Added
Individual/ Peer Reviewer		I would add and confirmed candida microbiology as a lot of people self report recurrent thrush and they don't have it at all. Instead they have herpes or eczema for example	Added
Individual/ Peer Reviewer		Consider adding "if no other risk factors identified" and explain to the patient that no clear evidence	Wording amended, link to BASHH for risk factors included. Individuals may choose to switch to an alternative f they perceive their symptoms are caused by their IUC, even if they may not be
Individual/ Peer Reviewer		Add that that we don't know re BV and IUS	Added
Individual/ Peer Reviewer		Again if no other risks/triggers identified and explain limited evidence (or no evidence with IUS)	Amended
Individual/ Peer Reviewer	14.5.1	Suggest adding somewhere to this section an explicit description of what is to be measured when assessing distance from fundus – is it from external serosa of uterus? Or is it from highest point of endometrium? Is it to the top of the body of the IUD? Or to the highest point of the IUD visible?	Clarified in text
Individual/ Peer Reviewer		? what about after history of more than 2 IUC expulsions?	This was considered by the GDG. However, the ultrasound scan only shows the IUC position at that given time and does not predict whether or not the IUC will remain in the correct (or incorrect) position. Therefore USS is not helpful in reassuring an individual that IUC will remain in the correct position.
Individual/ Peer Reviewer		**The evidence: risk factor** Can we summarize this to state what are the risk factors?	This has been summarized in the main text:
Individual/ Peer Reviewer	14.6	? Add – individuals with known distortion of the uterine cavity or known uterine malformation ? add IUC inserted within 48 hours after childbirth – esp vaginal birth	Amended

Individual/ Peer Reviewer		"The GDG suggests that if there have been ≥2 IUC expulsions, a pelvic ultrasound to assess the uterine cavity may be helpful prior to insertion of a third IUC." Suggest amend 'third' to 'further'.	Amended
Individual/ Peer Reviewer		***"When IUC is being inserted for gynaecological reasons, clinicians may wish to consider inserting the IUC after day 8 of the menstrual cycle."*** ? add the word "solely" before gynaecological	Not added as this would be an option whether the IUC was being inserted for only gynaecological reasons or gynaecological + contraception
Individual/ Peer Reviewer	14.7	Please could we have an indication of what risk of perforation we should be counselling women on if they are postpartum +/- breastfeeding? Currently I advise women perforation risk 6-12/1000 if breastfeeding. What risk should I be advising if postpartum/not breastfeeding?	Please see the evidence section in section 7.1.3.1 "After childbirth" for the available evidence on rates of perforation after childbirth
Individual/ Peer Reviewer		The other question that I get asked is "How long after stopping breastfeeding does the additional risk reduce to non-breastfeeding levels?"	There is no evidence available to inform this, however the fact that there is no evidence has now been added to section 7.1.3.1
Individual/ Peer Reviewer		Is there any evidence to support this recommendation? It seems counter intuitive when we recommend IUC may be fitted as early as 4 weeks after C section	No, there is not evidence to inform when it would be safe to insert IUC so the recommendation errs on the side of caution and was based on expert opinion from the GDG as in the text " In the absence of evidence, the GDG suggests waiting at least 6 weeks after a known or suspected uterine perforation before inserting a subsequent IUD" and is "suggests" rather than "must" for this reason. There may be a number of physiological differences or differences related to the site/position of the perforation/incision in the perforated uterus compared with the post LSCS sutured uterus
Individual/ Peer Reviewer	14.8.1	It would be helpful somewhere to put, that lost threads might be less likely if the threads are not cut too short! Can the writing group provide a an approx. minimum length eg. 3-4cm. This is based on a study on lost threads and thread lengths were measured and it was noted that the threads had been cut very short to begin with.	No studies were found that provided evidence of a recommended thread length and therefore GDG were unable to comment on a recommendation for thread length. Studies have suggested that non-fundal placement (and subsequent migration) may be associated with non visible threads and subsequent examination of the IUD shows shorter thread length. However, the threads are only shorter because the device was not placed up at the fundus at insertion.

Individual/ Peer Reviewer		Reasons for non-visible threads when an IUC is correctly sited includes … retraction of the threads, which could be caused by non-fundal placement at insertion …add **"and subsequent fundal migration/ upward movement"?**	Amended
Individual/ Peer Reviewer		If the device is not seen within the cavity, a plain X-ray of the abdomen and pelvis … or CT abdo (this is what we do on out trust)	CT added
Individual/ Peer Reviewer		If the device **is seen within the uterine cavity and** is to be removed…	Amended
Individual/ Peer Reviewer		….the threads may be located by inserting **a swab** or forceps…. (how does a swab facilitate removal?	Some services will only have larger forceps (e.g. sponge holders) for IUC removal. As these cannot be inserted into the cervical canal, a swab can be used to tease down threads that have curled up into the canal so they can be grasped by the forceps. Alternatively, a swab may sometimes be used to clear cervical mucus/blood from within the canal so that the threads can be visualized and then grasped. However, this has been amended for clarity
Individual/ Peer Reviewer		Thread problems after immediate PPIUC insertion; Very welcome section, thank you. I wonder if a flow chart for PPIUC follow up would be sensible like the NVT one on page 95? Flow charts are generally MUCH clearer and easier for clinicians to follow than a body of text. Please find our local one attached, which I would be happy for FSRH to use/adapt if including a flow chart and if use. Thank you for all your hard work CEU and GDG!	Thank you for your kind feedback. A flowchart has already been included as appendix
Individual/ Peer Reviewer	14.8.4	probably more accurately described as 'entire IUD is not/no more in the uterus'	Amended for clarity
Individual/ Peer Reviewer		please describe 'partial' first e.g. 'IUD is not/no more entirely in the uterine cavity', so may be in the cervical canal.	Order left as is for readibility
Individual/ Peer Reviewer		partial expulsions can be detected/confirmed by patients too, so consider removing 'only' from sentence in the brackets here	Amended

Individual/ Peer Reviewer		Is it an error that says 4 weeks post partum? ***'Plan for future contraception should be made with the user – if a further intrauterine method is requested and there is no risk of pregnancy, this can be inserted from 4 weeks' <u>postpartum</u> (Table 13)'***	No, this section is about immediate postpartum IUC insertion. IUC insertion is UKMEC3 until 28 days after delivery, hence the recommendation to insert from 4 weeks postpartum. This differs from manufacturer's advice (6 weeks) but is established standard practice in the UK and in line with previous CEU guidance
Organisation	S15	There has been some expectation that that the document would include guidance on the removal and changing of IUDs and its exclusion felt like a missed opportunity, especially the timing of the removal with amenorrhoeic women to determine if further contraception will be required in later stages of life.	Guidance on removal and changing of IUDs is included in the guideline in sections 10 and 15. Tables 14 and 16 provide guidance on timing and extra precautions required. Amenorrhoea is a recognized side effect for many individuals using an LNG-IUD and therefore bleeding/not bleeding with an LNG-IUD is not a marker of fertility or need for future contraception. Removal at menopause is included in Table 16. More detailed guidance on the need for contraception in perimenopause is included in the FSRH CEU 'Contraception for women aged >40' guideline.
Individual/ Peer Reviewer	S15.1	***"IUC users should be advised that IUC self-removal is not recommended..."*** please consider adding 'in the UK' here. In many countries including the USA, patient self-removal is an option and unrelated to access, more for patient autonomy and confidence re reversibility.	Amended
Individual/ Peer Reviewer	Table 18	***"Where this is not possible, consider EC ..."*** ? add in the case that the patient insists it is removed and accepts the risk of pregnancy even with oral EC	It is not possible to list all the clinical scenarios and keep the table succinct, however we hope that 'not possible' would include patient preference to remove, as well as clinical indications for removal
Individual/ Peer Reviewer	15.3.1	It would be helpful to add what imaging is required depending on the bit missing. Please clarify Eg. USS for plastic or copper X-ray for plastic?	This section has been reworded and further advice given which I hope is helpful. Both plastic and copper may be visible on USS, XR and CT but where only small fragments are present then other factors (size, position, patient anatomy, experience of performing the imaging/interpreting the imaging) may play a part. See evidence section for limitations.

Individual/ Peer Reviewer		And if USS / X-ray negative – should we proceed to CT (as long as PT neg)? Especially if we don't know the effect on fertility and the patient is keen to conceive at some point	Unfortunately there is a lack of published literature in this area and therefore it is not possible to make any evidence based guidance. Due to this absence of evidence, the GDG have suggested the risk/benefits need to be considered on a case by case basis depending on the individual's circumstances. Further information has been added for suspected perforation.
Individual/ Peer Reviewer	S15.3.3	or even embedding/partial perforation.	Added
Individual/ Peer Reviewer	Appendix	The implant guidance has helpful Appendices for suggested Nexplanon insertion and removal procedure Are you planning similar for IUC insertion and removal?	Unlike the implant, there are multiple types of IUD with different insertors, ways of loading and ways of deploying the devices, so we would either need to have different insertion guides for different IUDs (which would not be practical for the guideline and may become out of date) or have a very basic guide really just detailing the pre-insertion procedure then signposting to manufacturer's advice on insertion for that particular device and it was felt that would not be especially helpful. Instead we have included guidance on the pre-insertion procedure (bimanual, speculum, sounding) in the insertion section of the guideline and a link to the removal technique film has been included in the guideline.

Other comments

Overall usefulness

We are grateful for the very kind comments from reviewers that recognise the value of this guideline in informing clinical practice.

Guideline layout, writing style and length

We fully acknowledge that the guideline is lengthy. The guideline was written with a digital format in mind; we anticipate users will go directly to specific sections and therefore felt that it was important for each section to have enough information to be a stand-alone document. Where possible, to avoid duplication of text, readers have been signposted to the relevant sections of the guideline for further details.

An innovation to the presentation of this guideline is to relocate the evidence supporting the clinical recommendations and key information points to an appendix; with hyperlinks included in the main text to direct readers to the relevant evidence section in the appendix and a hyperlink will bring readers back to the relevant section in the main guideline. This 'evidence relocated' version is a Member's Benefit and FSRH members should log into their MyFSRH account to access this.

A quick reference summary has been produced that will include the useful tables and figures to support clinicians to using the guideline during consultation. This is a Member's Benefit and FSRH members should log into their MyFSRH account to access this.

FSRH guideline Intrauterine contraception can be accessed here. All comments on FSRH Guidelines can be sent directly to the CEU via the FSRH website (www.fsrh.org).

The Clinical Effectiveness Unit (CEU) was formed to support the Clinical Effectiveness Committee of the Faculty of Sexual and Reproductive Healthcare (FSRH), the largest UK professional membership organisation working at the heart of sexual and reproductive healthcare. The CEU promotes evidence based clinical practice and it is fully funded by the FSRH through membership fees. It is based in Edinburgh and it provides a member's enquiry service, evidence based guidance, new SRH product reviews and clinical audit/research. Find out more here.