Letters to the Editor

Send letters to afplet@aafp.org, or 11400 Tomahawk Creek Pkwy., Leawood, KS 66211-2680. Include your complete address, e-mail address, and telephone number. Letters should be fewer than 400 words and limited to six references, one table or figure, and three authors.

Letters submitted for publication in *AFP* must not be submitted to any other publication. Possible conflicts of interest must be disclosed at time of submission. Submission of a letter will be construed as granting the AAFP permission to publish the letter in any of its publications in any form. The editors may edit letters to meet style and space requirements.

This series is coordinated by Kenny Lin, MD, MPH, Associate Deputy Editor for *AFP* Online.

Optimal Time for IUD Insertion After an STI

Original article: Intrauterine Devices: An Update

Issue date: March 15, 2014

Available at: http://www.aafp.org/afp/2014/0315/p445.html

TO THE EDITOR: The authors of this article recommend waiting three months after resolution of a known sexually transmitted infection (STI) before inserting an intrauterine device (IUD). In my opinion, there is no evidence to support this restriction. The American College of Obstetricians and Gynecologists recognizes that there is no known optimal time for IUD insertion after the diagnosis of an STI.[1] The Centers for Disease Control and Prevention's U.S. Selected Practice Recommendations and U.S. Medical Eligibility Criteria do not mention any specific amount of time to delay IUD insertion after an STI is diagnosed.[2] For women at high risk of becoming pregnant, placing an IUD three to four weeks after treatment would be reasonable. The best approach will depend on the individual patient's circumstances.

KYOKO PEÑA-ROBLES, MD, MPH
Pleasant Hill, Calif.
E-mail: kyokopena@yahoo.com

Author disclosure: No relevant financial affiliations.

REFERENCES

1. American College of Obstetricians and Gynecologists. ACOG practice bulletin no. 121: long-acting reversible contraception: implants and intrauterine devices. *Obstet Gynecol.* 2011;118(1):184-196.
2. Centers for Disease Control and Prevention. U.S. selected practice recommendations (US SPR) for contraceptive use, 2013. http://www.cdc.gov/reproductivehealth/unintendedpregnancy/usspr.htm. Accessed September 2, 2014.

IN REPLY: We thank Dr. Peña-Robles for the comments regarding our article. Although the American College of Obstetricians and Gynecologists and the Centers for Disease Control and Prevention do not specify an optimal time for IUD insertion after diagnosis and treatment of an STI, that lack of specificity does not provide useful guidance to readers of *American Family Physician.* On the other hand, the Planned Parenthood Federation recommends against IUD insertion within three months of the diagnosis and treatment of an STI.[1] Because this is the only published recommendation on the issue, it seemed most useful to provide readers with that information. Dr. Peña-Robles' suggestion that IUDs be placed three to four weeks after STI treatment might be equally safe, but there are no published guidelines or studies supporting a shorter time interval.

JULIA A. HARDEMAN, MD
BARRY D. WEISS, MD
Tucson, Ariz.
E-mail: julia.hardeman@uahealth.com

Author disclosure: No relevant financial affiliations.

REFERENCE

1. International Medical Advisory Panel. IMAP statement on intrauterine devices. *IPPF Med Bull.* 2003;37(2):1-4.

Considerations for Identifying Ectopic Pregnancy

Original Article: Diagnosis and Management of Ectopic Pregnancy

Issue Date: July 1, 2014

Available at: http://www.aafp.org/afp/2014/0701/p34.html

TO THE EDITOR: The authors mention that visualizing intrauterine gestational structures effectively rules out an ectopic pregnancy given the rarity of heterotopic pregnancy. However, it has been estimated that up to 1% of pregnancies conceived with assisted reproductive technologies are heterotopic,[1] and with patients increasingly using such technologies, family physicians should maintain a high index of suspicion.

Also, one modality not discussed in the article is dilation and curettage, which can be performed in cases of assured nonviable pregnancy of unknown location. If there is an absence of chorionic villi in the pathologic specimen, then one can reasonably diagnose an ectopic pregnancy in the presence of other indicators, such as decreasing or inappropriately increasing quantitative human chorionic gonadotropin levels, even in the absence of diagnostic ultrasonographic findings. This approach can often save a woman from undergoing an invasive exploratory laparoscopic procedure.

AMIT BHAVSAR, MD
Honolulu, Hawaii
E-mail: amitbhavsar@me.com

Author disclosure: No relevant financial affiliations.

REFERENCE

1. Svare J, Norup P, Grove Thomsen S, et al. Heterotopic pregnancies after in-vitro fertilization and embryo transfer—a Danish survey. *Hum Reprod.* 1993;8(1):116-118.

IN REPLY: Assisted reproductive technologies increase the risk of heterotopic pregnancy, although likely less than the 1% rate observed in a 1993 Danish survey.[1] A more recent analysis of all registered assisted reproductive technology pregnancies in the United States from 1999 to 2002 reported an incidence of heterotopic pregnancy of 1.5 per 1,000 assisted reproductive technology pregnancies, or 0.15%.[2] Nevertheless, we agree that clinicians must be aware of this possibility when treating a patient with a pregnancy of unknown location.

Although dilation and curettage has been advocated by some experts as a tool to assist in the diagnosis of a pregnancy of unknown location, this procedure risks disrupting a viable pregnancy. Furthermore, the absence of chorionic villi does not confirm an ectopic pregnancy because false-negative results are common; chorionic villi are not detected by histopathology in up to 20% of curettage specimens from elective termination of pregnancy.[3]

Finally, with the advent of methotrexate as a treatment option for suspected ectopic pregnancy, women can now routinely avoid the possibility of undergoing an invasive exploratory laparoscopic procedure, or even a less invasive curettage.

JOSHUA H. BARASH, MD
Philadelphia, Pa.
E-mail: joshua.barash@jefferson.edu

Author disclosure: No relevant financial affiliations.

REFERENCES

1. Svare J, Norup P, Grove Thomsen S, et al. Heterotopic pregnancies after in-vitro fertilization and embryo transfer—a Danish survey. *Hum Reprod.* 1993;8(1):116-118.
2. Clayton HB, Schieve LA, Peterson HB, Jamieson DJ, Reynolds MA, Wright VC. A comparison of heterotopic and intrauterine-only pregnancy outcomes after assisted reproductive technologies in the United States from 1999 to 2002. *Fertil Steril.* 2007;87(2):303-309.
3. Lindahl B, Ahlgren M. Identification of chorion villi in abortion specimens. *Obstet Gynecol.* 1986;67(1):79-81. ■