weeks are precipitated by the injury, and nowhere in our report did we state that we used this interval other than as a convenient cut off for our simple study. In fact, we stated this clearly in the first paragraph of the comment section.

We agree that the practice of omitting the fracture from the death certificate should be condemned—a point that we thought was implicit in our paper. It does, however, happen—often, as shown by our findings, and usually after discussion between a junior doctor and the coroner's officer, and we should not pretend otherwise.

There is no doubt that practice differs between coroners' offices across Britain. This point is well made in Martyn Parker's letter and is clear from the tone of the letter from Rutty and colleagues and by comments from other sources. We consulted the appropriate authorities in Leicestershire before reaching our conclusions. We also agree with Parker's comment about the distress caused to relatives. The idea that postmortem examination should be carried out in all cases, proposed by Ian S D Roberts and Emyr W Benbow, might be resisted by relatives for the same reason.

Our study attempted to make the simple point that hip fracture is often omitted from death certificates for inappropriate reasons, thereby causing inaccuracies in official mortality statistics; this seems to have been missed by some readers, which may partly be due to the brevity of our report. Clearly, the medicolegal concepts relating to deaths soon after hip fractures have not been made clear to many junior medical staff and coroners' departments, and a smoother process might be beneficial for everyone.

S J CALDER
Research registrar
P J GREGG
Professor

University Department of Orthopaedic Surgery,
Glenfield General Hospital,
Leicester LE3 9QP

G H ANDERSON
Senior registrar

Department of Orthopaedic Surgery,
Leicester Royal Infirmary,
Leicester LE1 5WW

ABC series may be anachronistic in era of evidence based medicine

EDITOR,—Are the ABC series now an anachronism? As the medical profession moves into the era of evidence based medicine, what is the place of articles that do not distinguish evidence (or the lack of it) from personal prejudice (in its original sense of "prejudged")?

In their article on prostate cancer in the ABC of Urology, Chris Dawson and Hugh Whitfield begin with the uncertainties and inadequacies of the options for screening for prostate cancer.¹ They then suggest that the key is to find a test that can differentiate between those cancers that are indolent and those that are going to be clinically important. Without substantiation they say that measurement of prostate specific antigen may be able to do this and therefore may be valuable as a screening tool.

We do not agree. The question is even more fundamental: what evidence is there that any treatment of prostate cancer offers increased survival? Until there is evidence of benefit it may be legitimate to ask whether any treatment other than symptomatic treatment is justified, let alone whether we should be treating people who are asymptomatic.

To return to our initial question, we wonder how continuing medical education articles should look in an era of evidence based medicine. Can busy clinicians overcome the time constraints to work out their own management policies from original data? If not, the job of arti-

cles such as this is to synthesise the data in as palatable a manner as possible to allow clinicians to use them to offer the best possible care. We need to know what is established in the literature with good evidence, what is best practice in its absence, and what is the author's personal but possibly idiosyncratic choice—that is, the quality of the information must be labelled.^{2,3}

C B DEL MAR
Professor
PAUL P GLASZIOU
Senior lecturer

Centre for General Practice,
University of Queensland,
Australia

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*To be useful, educational material must be valid and relevant and accessible to doctors without them having to work too hard to absorb the material. Our ABC series are hugely popular with all sorts of doctors and students because they are seen as highly relevant and easy to read. C B Del Mar and Paul P Glasziou are right to raise the question of how evidence based—and therefore valid—the ABC series are. We have addressed this question ourselves and issued guidance to authors on how to make the material as evidence based as possible. We decided against including references for all statements, although we do now include key references. We are anxious to maintain the directness and simplicity of the series.—EDITOR

Contraceptive implants

High resolution ultrasonography facilitates removal

EDITOR,—David R Bromham's editorial on contraceptive implants is aimed at correcting incomplete or inaccurate information about levonorgestrel implants.¹ In his discussion of removal of such implants, however, his cited reference states that "migration of more than 2 cm, to our knowledge, has never been reported."² Migration of the capsules is likely to cause difficulty in removal. I report a case in which migration of greater than 2 cm occurred.

Levonorgestrel implants comprise six capsules of 34 mm, which should fan out regularly above the site of insertion. Some time after insertion in a 30 year old woman two capsules were found to be in a satisfactory position; the third, fourth, and fifth to have migrated cranially by roughly 15 mm, 40 mm, and 40 mm, respectively; and the sixth to have migrated over 50 mm caudally. The capsules had been inserted by a general practitioner who had undertaken the approved training course. All of them were located with high resolution ultrasonography. The patient did not want them removed.

I am surprised that migration of levonorgestrel capsules of more than 2 cm has not been reported previously and suspect that this represents underreporting rather than an extremely low incidence. The phase III trial of levonorgestrel implants (which used only two rods) showed a 5.8% incidence of migration (85 of 1466 women).³ The distance migrated was not stated in any of these cases, but in two cases removal was required because the implants had migrated to the elbow crease, causing inconvenience. The authors noted that migration (and expulsion of capsules and infections) occurred only when the implants had been inserted early in the trial, when experience in insertion and removal was limited. The extent of this learning

curve was not specifically addressed, but it is possible that higher complication rates might occur if the people inserting the capsules insert small numbers each year.

Various methods have been advocated for facilitating removal of capsules that are difficult to locate, including radiography, computed tomography, fluoroscopy, and ultrasonography. My experience leads me to agree with Thurmond *et al*,⁴ who recommended high resolution ultrasonography for accurate, simple localisation without the use of ionising radiation. Using ultrasound guidance, I have marked the skin directly over the length of the implant and recorded the depth beneath the surface in three other cases in which one or more implants proved difficult to remove. This facilitated removal in each case. It is important that the arm is in the same position as that used for removal.

N J A COZENS
Consultant radiologist

Department of Radiology,
Derbyshire Royal Infirmary,
Derby DE1 2QY

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- 4 Thurmond AS, Weinstein AS, Jones MK, Jensen JT, Nichols MD. Localisation of contraceptive implant capsules for removal. *Radiology* 1994;193:580-1.

Complete, understandable information is essential

EDITOR,—We share David R Bromham's concern that users lose out when misleading information about contraception limits choice.¹ Between September 1993 and the end of June 1995, levonorgestrel implant capsules were inserted on 184 occasions in the community family planning clinics in Manchester. All were inserted by doctors during or after completion of the training programme organised by the manufacturers.

We carried out an audit of all the women who had had implants inserted. Our outcome measures were continuation rates and levels of satisfaction among recipients. We sent questionnaires to the 175 women who accepted correspondence to their home, and we looked at all the clinic notes. When appropriate we contacted the women's general practitioners for further details. By the end of June 1995, 27 implants had been removed, giving continuation rates at 6, 12, and 18 months of 98% (154/157), 88% (94/107), and 76% (26/34), respectively. All the removals except one were completed within the advised maximum time of 30 minutes, and many were done a lot faster. The exception was in a woman who asked not to have all the rods removed at once. A large number of the removals were carried out by doctors under supervision during training; initially the original technique was used, but this was then superseded by the easier and quicker "U technique." The most common reason for removal was irregular bleeding; the other reasons were similar to those mentioned in the literature.²

One hundred (57%) women returned their questionnaire, and for a further 44 (25%) recent information was available in the clinic's or general practitioner's notes. Seventy seven of the 100 women were either very or reasonably satisfied with the implant. Of the 10 who were disappointed, six said they had had enough information and that it was unfortunate that they had developed problems; only four thought that they had not had enough information.