LETTERS

Letters to the Editor

Menstrual problems in women with intellectual disability

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The article on managing menstrual problems for women and girls with intellectual disability[1] was a very thorough review of the various medical, social and ethical dilemmas faced by clinicians. However, I would like to draw attention to the use of long-acting reversible contraception in these patients.

Insertion of the levonorgestrel-releasing intrauterine device (Mirena) into a uterine cavity less than 6 cm (by ultrasound) may increase the incidence of expulsion, bleeding, pain, perforation, and possibly pregnancy. Its use may therefore be limited in younger patients with intellectual disability.

The use of the medroxyprogesterone injection (Depo-Provera or Depo-Ralovera) appears to be associated with weight gain, particularly in those under 18 years who may already be overweight or obese.[2] Also, its use in women under 20 years has been associated with lower bone density.[3]

The etonorgestrel implant (Implanon) provides reliable contraception and results in amenorrhoea in up to 22% of women. If bleeding patterns are unacceptable, the implant can be used with a low-dose combined oral contraceptive pill or progestogen-only pill if amenorrhoea and long-acting reversible contraception is required and other methods are not preferred.[4,5]

The article discussed the potential for sexual abuse and consent. The perpetrators of sexual abuse may include family members, support workers or co-residents. People with an intellectual disability may not be assertive enough to report the abuse or have the verbal skills to articulate it.[6] Using the etonorgestrel implant which is palpable on the arm may further increase the risk of abuse as the perpetrator is aware of its presence.

I hope other readers will derive benefit and certainly offer better care to their patients with intellectual disability.

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Jane Tracy, one of the authors of the article, comments:

We thank the reader for the valuable comments made and wholeheartedly support their commitment to improving the care of patients with an intellectual disability. Our article was intended to provide an overview of the approach to supporting women to manage their menstruation, rather than focus on the medications because the drug effects are, in general terms, the same for women with and without disability. We agree, however, that the hormonal products discussed can cause irregular bleeding which may cause particular challenges for some women with intellectual disability. For others, they have been liberating when menorrhagia and dysmenorrhoea have previously limited activities and quality of life.

The reader's point about the use of contraceptives increasing the risk of sexual abuse when the perpetrator knows that pregnancy is unlikely to follow is shocking and true, and underlines the vulnerability of these women and girls. It follows that we, as medical practitioners caring for our patients, must be all the more vigilant to the possibility of abuse. Suspicion may be raised by genital symptoms (irritation, lacerations, bruising), infections, or the appearance of new behaviours characterised by fear, avoidance of certain situations or people, or behaviours of a sexual nature.

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We encourage medical practitioners to review the care of their patients with intellectual disability to ensure optimal physical and mental health, including social, sexual and reproductive health, to optimise opportunity, function and quality of life for all.