REPLY

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We thank Dr Singh Mahla for his interest in our study.[1] Part of our motivation to publish these data was to address the misconception that intrauterine devices (IUDs) should be used only for contraception and are linked directly to sexual activity, including the assumption that only sexually active women are able to tolerate an invasive pelvic exam.

As reviewed in the background of our study, hormonal IUDs have many noncontraceptive benefits.[1] This treatment option should not be withheld from adolescents suffering from dysmenorrhea, chronic pelvic pain, and heavy menstrual bleeding because of the lack of sexual activity. By offering different treatments to adolescents based on sexual activity status, we are discriminating against girls who are not sexually active.

We would like to clarify that levonorgestrel-containing IUDs were the primary IUDs placed in our study, and the background thus focused on the noncontraceptive benefits of hormonal IUDs.[1] The copper (Cu T 380a) IUD was placed in very few (n = 3) sexually active participants in our study.[1] In the retrospective cohort study from Bangladesh quoted by the author, only copper IUDs were studied, which we believe is not applicable to our study.[2] The mechanism of action significantly differs between these devices.

To the author's second point, the purpose of our study was not to address protection against sexually transmitted diseases. The author asserts that hormonal IUDs accelerate HIV infection, but this is not consistent with our review of the literature, including a recent systematic review.[3] In women using the hormonal IUD for noncontraceptive benefits, the risk of sexually transmitted infections is irrelevant because abstinence prevents these infections.

The author's statement that IUDs cause psychological and physiological harm is unfounded, and he does not provide a reference for this claim. Our study does not argue that the IUD is the best treatment method for every patient. It does, however, illustrate that IUD insertion is tolerated well in the majority of never sexually active patients.[1] We maintain that physicians should advocate for their patients to receive the best treatment for contraception and menstrual disorders and that lack of sexual activity should not preclude adolescents from being offered this effective option. ■

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An instrument which addresses the expectations of pregnant women over childbirth

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TO THE EDITORS: Recently an article entitled "Childbirth-specific patient-reported outcomes as predictors of hospital satisfaction" was published in this Journal.[1] The study concluded that practices that precede childbirth and postpartum can enhance the childbirth experience as well as the pregnant mother's and family's satisfaction. The study states that in the hospital setting, it is necessary to develop strategies to improve childbirth experience.

Hence, we consider it appropriate to add that it is fundamental to know and assess the pregnant woman's expectations about what they expect from it because these often determine the type of delivery they choose, influencing directly in the postpartum satisfaction. Likewise, it is fundamental that health professionals provide guidance about the possibilities of situations and necessary procedures at the delivery moment, according to the yearnings reported by the woman.

It is known that when the lived experience differs from the imagined moment, the probability of dissatisfaction increases.[2] Thus, the selection of an instrument that addresses