

Localised lipoatrophy at the site of Implanon® insertion

A 40-year-old woman, who had had an Implanon® implanted into her right upper arm 3 years before for the first time by an experienced practitioner regularly undertaking the procedure, presented asking for the implant to be removed.

She had been pregnant twice in the past, having had two normal deliveries of healthy children. She had suffered atopic eczema from childhood and was still subject to exacerbations that were treated with low-dose topical steroids and emollients. During the first year the Implanon was in place she had regularly taken paroxetine for obsessive compulsive disorder. She had a body mass index of 24 kg/m² but had not gained or lost weight. She had been amenorrhoeic whilst the Implanon was in place. She was otherwise well with no other past history. She had no family history.

At the site of the Implanon in the middle of the inner aspect of her right upper arm she had a localised area of lipoatrophy extending approximately 2 cm either side of the implant and along a length of approximately 15 cm extending above and below the ends of the implant. In this 4 × 15 cm area there was virtually no subcutaneous fat. The lipoatrophy had been asymptomatic and had to be demonstrated to the patient who did not want another implant because she and her partner had decided to use barrier contraception.

A foreign body reaction and expulsion of Implanon has been described.¹ Lipoatrophy has been described as an immunologically mediated inflammatory response within adipose tissue.² It seems possible that localised lipoatrophy may be another rare complication of Implanon use. It is intended to review the patient at 6 and 12 months to observe whether adipose tissue has regrown.

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Reply

We would like to thank Dr Lindsay for reporting a case of lipoatrophy during treatment with Implanon® in a patient who suffered atopic eczema from childhood and was still subject to exacerbations that were treated with low-dose topical steroids and emollients.¹

Localised lipodystrophy, or lipoatrophy, is a syndrome characterised by scattered atrophic areas with loss of subcutaneous fat and may be due to various conditions such as withdrawal of steroid treatment, insulin injections, trauma, or sequels of panniculitis in connective tissue. Localised lipoatrophy at the site of insertion of Implanon has never been described before. In the case reported by Dr Lindsay, a potential confounder or alternative explanation is atopic eczema or its treatment. A potential association between lipoatrophy and autoimmune disease was proposed by Billings *et al.*,² who described three children with lobular panniculitis that

resulted in extensive atrophy. Martinez *et al.*³ described an association between extensive lipoatrophic panniculitis and chromosome 10 abnormality. As Dr Lindsay suggests, follow-up and further immunological investigation of this case would be helpful in understanding the aetiology of this condition. We are looking forward to reading more about the follow-up. This case has been reported as an adverse event to the Medicines and Healthcare products Regulatory Agency (MHRA).

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Acceptance of ligation and resection of tubes for contraception in Sri Lanka

Sri Lanka has a successful family planning programme in comparison to other South Asian countries.¹ Though many had predicted the total fertility rate to be at or below 2.0, the most recent demographic and health survey estimates it to be at 2.4.² Ligation and resection of tubes (LRT) was in demand as a method of contraception in the early 1980s. Since then the LRT rates have continuously declined, with only 10 228 female sterilisations performed in 2005 compared to 27 000 in 1997 and 15 500 in 2000.³ This trend was favoured by the government, which imposed restrictions or eligibility criteria for women seeking LRT from 1988.⁴

We did a cross-sectional survey of women fulfilling eligibility criteria for LRT (age >26 years, already having two or more children and if having only two children the last child being more than 2 years of age)⁴ to identify what proportion of these women are willing to undergo LRT and how race, religion, level of education and family income would influence the decision. The sample was selected from the Sri Lankan capital, Colombo, and its suburbs.

There were 131 eligible respondents, of whom 120 (91.6%) had heard of LRT. Sixty (46%) women expressed a willingness to undergo the procedure. Fifty-three (40.5%) women said their husbands approved, and 28 (21.4%) said their husbands rejected the idea. The remainder (50 women, 38.2%) did not know their husband's opinion on the matter. There was no statistically significant difference for acceptance of LRT based on differences in race (Sinhala, Tamil, Muslim), religion (Buddhism, Islam, Hinduism, Roman Catholicism), level of education and family income ($p>0.05$).

Our sample showed that there is a significant demand for LRT, with 46% of women accepting

it as a method of contraception. In fact, 39% ($n=51$) of the total sample had approached a health care worker about the subject, thus showing that they had given the matter serious thought. However, national statistics suggest a decline in female sterilisations over time (female sterilisation was used as a means of contraception by 23.1% of ever-married women in 2000 compared to 16.9% in 2007).²

There may be several factors responsible for this observed disparity. First, given the government restrictions and parents opting for smaller family sizes, the number of women eligible for sterilisation may be less. Second, even if there is a demand, the facilities for sterilisation may not be adequate in peripheral locations. Currently most sterilisations in Sri Lanka are performed in the government sector (free of charge to the client) with hospitals from base hospital level upwards providing the facilities (approximately 100 hospitals for a total population of 20 million).⁵ However, in recent years, smaller yet more peripherally located district hospitals have been upgraded to provide LRT facilities.⁵ Third, unawareness or misconceptions about LRT and preference for modern reversible contraceptive methods may be responsible for the declining numbers of sterilisations performed. Fourth, our sample (from an urban setting) may not be representative of the majority of eligible women in Sri Lanka, who are still living in rural areas where access to information is restricted and attitudes may be different.

On the basis of these preliminary findings, we recommend further studies with nationally representative samples to explore the demand for sterilisation and the reasons for the declining number of procedures performed. If the demand is still there and it is properly addressed, sterilisation can be cost effective compared to the use of the depot medroxyprogesterone acetate injection, which is gaining in popularity in Sri Lanka.³

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LETTERS TO THE EDITOR

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