Case Report

Table 1 Case reports of perforations with the Gynefix device to date

<table>
<thead>
<tr>
<th>Year</th>
<th>Authors</th>
<th>Time until removal</th>
<th>Mode of presentation</th>
<th>Previous progestogen used</th>
</tr>
</thead>
<tbody>
<tr>
<td>1996</td>
<td>Vekemans and Verougstraete</td>
<td>10 weeks</td>
<td>Pain</td>
<td>None stated</td>
</tr>
<tr>
<td>2000</td>
<td>Al-Kamil</td>
<td>12 days</td>
<td>Pain</td>
<td>Norplant (4 years)</td>
</tr>
<tr>
<td>2001</td>
<td>Reuter and Krishnamurthy</td>
<td>5 months</td>
<td>Cramps and pain</td>
<td>Depo-Provera</td>
</tr>
<tr>
<td>2001</td>
<td>Gandhi et al.</td>
<td>11 days</td>
<td>Pain</td>
<td>Progestogen-only pill</td>
</tr>
<tr>
<td>2001</td>
<td>Gandhi et al.</td>
<td>3 months</td>
<td>Pregnancy</td>
<td>None stated</td>
</tr>
<tr>
<td>2002</td>
<td>Aust et al.</td>
<td>2 months</td>
<td>Strings not visible</td>
<td>Depo-Provera</td>
</tr>
</tbody>
</table>

The impalpable Implanon®: a case report

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Abstract

This is a case report of an Implanon® contraceptive device that was impalpable after insertion and a discussion of the management of the impalpable Implanon.

Case report

A 16-year-old girl currently using Depo-Provera® for contraception attended the family planning clinic with a view to a change of contraceptive method because of weight gain on Depo-Provera. She was informed of her contraceptive options and in particular the contraceptive implant, Implanon. Implanon is a single-rod, non-biodegradable, contraceptive implant containing 68 mg etonogestrel. The mode of action, insertion and removal method and side effects including menstrual disturbance were fully explained to her. She consented to insertion. Implanon was inserted using the standard method into the medial side of her right arm, 8 cm above the elbow in the biceps/triceps groove.

After insertion the implant was impalpable. The patient was informed that it was possible that the implant was too deep to palpate or perhaps had not left the loading system. She was protected from pregnancy by her still active Depo-Provera.

An ultrasound of the patient’s upper arm failed to detect the implant. X-ray was not utilised as Implanon is not radiopaque. As the ultrasound department was not familiar with ultrasound use in the location of Implanon and deep insertion could not be confidently excluded, a magnetic resonance imaging (MRI) scan was recommended.

In the meantime a further Implanon was inserted, with the patient still under contraceptive cover from the Depo-Provera.

The MRI scan revealed a single device in the subcutaneous fat. Localisation was aided by placing an oil capsule on the skin, at the site of insertion. A surface coil is necessary for the best image quality. Figure 1 shows the Implanon in axial section, as a low signal (black) structure, or signal void, just beneath the skin, with surrounding high signal (white) rim. Higher signal from the adjacent subcutaneous fat acts as contrast. Figure 2 is a coronal section using a fat suppression sequence (STIR). The Implanon has a low signal, and would be lost against the background low signal of subcutaneous fat, but is highlighted by a raged high signal rim. This high signal represents the oedema following insertion, which persists for several days.

The patient was informed that she did only have one...
Implanon in situ and that the first device had never reached her arm during insertion.

Five months later the patient no longer had a need for contraception and had polymenorrhoea, menstrual cycle 7/14, and the Implanon was removed at her request.

Discussion

This is the second case of an Implanon ‘lost’ at the time of insertion seen within our department. An Implanon may be impalpable because of failed insertion technique (non-insertion), deep insertion or, very rarely, because of migration from the insertion site. If at any point after insertion an Implanon is impalpable after careful palpation of the insertion site feeling for the proximal and distal ends of the device, deep into the biceps/triceps groove and muscle bulk then alternative contraception should be recommended.

Ultrasound has been proposed as the investigation of choice. High or very high frequency transducers provide good resolution and are most effective at detecting Implanon. Implanon may first be located by its distinct acoustic shadow and its exact position identified as an echogenic spot. Once the Implanon has been located a longitudinal view will allow both tips to be located. However, our experience suggests that ultrasound localisation is only practical when the device is lying very superficially. If the Implanon is deep in the muscle or soft tissue it may be difficult to identify, since the diameter of the rod is close to the resolution of the ultrasound probe.

MRI is suggested, as a second-line imaging modality, although its use will be restricted in some areas because of cost and access. Implanon is not detectable by computed tomography scanning. Implanon produces low signal or a signal void on MRI and therefore is seen as a dark area on Implanon insertion. MRI may be used as a second-line imaging method.

Since it is coming up to 3 years since the first Implanon devices were inserted, women will now be returning to have them removed. Some women will have an impalpable Implanon; by close liaison between radiology departments and clinicians most Implanon devices will be localised by a combination of ultrasound and MRI scanning techniques.

Only a careful insertion technique and confirmatory palpation of the implant by patient and inserter will prevent Implanon insertion and removal difficulties.

Statements on funding and competing interests

Funding. None identified.

Competing interests. Dr Searle has received payment for delivering training sessions on Implanon insertion. Dr Stillwell has received funding from Organon to attend scientific meetings and to deliver training sessions on Implanon insertion.

References

2 Merki-Feld GS. Nonpalpable ultrasonographically not detectable: Implanon rods can be localised by MRI. Contraception 2001; 63: 325–328.