LETTERS

Williams has already eloquently answered the question as to whether LBC offers any real advantage over the conventional smear technique. We agree that LBC is a very welcome technological tool in the screening programme and would encourage ongoing endeavours to explore how LBC can bring further benefits to women’s health.

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References
4 Williams AR. Liquid-based cytology and conventional smears compared over two 12-month periods. Cytopathology 2006; 17: 82-95.

Implanon® insertion

I was interested to read the articles in the July 2006 issue of the Journal regarding problems related to the insertion of this device.

I recently inserted an Implanon device into the left arm of a 23-year-old, right-handed patient. The procedure went smoothly. Eleven days after the insertion the patient presented with a 3-day history of a red rash around the site of the implant. On examination she had a lymphangitis-type reaction extending proximally and distally from the site of the implant. She was otherwise well with no systemic symptoms. The patient was commenced on oral fusidic acid.

Three days later the patient was reviewed. The erythema had resolved. A sclerotic vessel was palpable extending from just deep to the implant to the mid-forearm. It was not tender. The patient experienced some discomfort on full extension of the arm but as she was otherwise well had opted to leave the implant in situ. A diagnosis of thrombophlebitis was made.

I can find no mention of this complication in the product or FPPRHC literature. I wonder if others have also seen similar cases?

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References
1 Fraser IS. The challenges of location and removal of Implanon®-containing implants. J Fam Plan Reprod Health Care 2006; 32: 151-152.

Full-term pregnancy with Implanon® in situ

I write in regard to the letter on full-term pregnancy with Implanon® in situ by Drs Cooling and Pauli that appeared in the July 2006 issue of the Journal.

I had a similar experience when I fitted an Implanon in a patient who, in retrospect, was probably about 4 months pregnant. She gave a history of regular periods and was bleeding when I fitted it. She had not had unprotected sexual intercourse at all preceding the history.

The patient then had amenorrhea for several months and presented to her general practitioner with abdominal swelling and weight gain. She was obviously in advanced pregnancy (perhaps not the world’s brightest!).

She was 36 weeks pregnant and the hospital contacted me to see if the Implanon should be removed. I could not see any reason for doing so at such a late stage. The patient delivered without problem and chose not to breastfeed. She at least now has effective contraception for a few years!

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Reference

Full-term pregnancy with Implanon® in situ

I read with interest the letter in the July 2006 issue of the Journal regarding a successful full-term pregnancy with Implanon® in situ. I too have a patient who presented in similar circumstances and is continuing her pregnancy with the Implanon in situ as she would wish to use this method of contraception following her confinement.

After discussion with the patient and colleagues, it seemed that to leave the Implanon in place was an option. Time will reveal the outcome in due course.

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Reference

Full-term pregnancy with Implanon® in situ

The case of the full-term pregnancy with Implanon® in situ reported by Drs Cooling and Pauli in a recent issue of this Journal raises several interesting issues.

First, influence of pregnancy on Implanon. As stated by the authors, the rate of release of the progestogen from the implant is likely to be unaltered in pregnancy. Also, the effects of the progestogen (both in terms of intended action and side effects) are likely to be overwhelmed by the massive increase in the placental production of progesterone.

Second, influence of Implanon on pregnancy. The authors correctly state that “progestogen in pregnancy have not been linked with fetal abnormality” which applies only to low doses of progestogen. High doses (>10 mg per day of norethisterone or equivalent) has been associated with masculinisation of a male fetus and hypospadias of the male fetus.2 It is accepted that the dose of progestogen released by Implanon is low at 40 µg per day.


References

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References

Reply

Dr Arunakumari identifies several important points. The negative urine pregnancy tests remain puzzling since the ultrasound scan performed at 27 weeks would suggest the Implanon® was inserted when the patient was 8 weeks pregnant (i.e. 6 weeks after conception). This means, however, that organogenesis would not have been completed by the time of insertion. Dr Arunakumari is, of course, correct that pregnancy is a contraindication to use of Implanon. However, the issue in this case, as in Dr Melrose’s case, is that removal and postnatal re-insertion of Implanon at this late stage in pregnancy subjects the patient to two extra