LETTERS

Williams\(^1\) 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 advance in the capability of the smear test and would encourage ongoing endeavours to explore how LBC can bring further benefits to women’s health.

Arabinda Saha, MD, MRCOG
Consultant in Obstetrics and Gynaecology, Diana, Princess of Wales Hospital, Scartho Road, Grimsby, North East Lincolnshire DN33 2BA, UK. E-mail: arabindasha@mtn.com

Kathryn Snee, MSc, FBMS
PathLinks Cytology Manager, Lincoln County Hospital, Donnington Road, Lincoln, Lincolnshire, LN2 5QY. E-mail: kathy.snee@uhl.nhs.uk

References

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Implanon\(^{\text{TM}}\) insertion

I was interested to read the articles in the July issue of the Journal regarding problems relating to the insertion of Implanon.

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 Flucloxacillcin.

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 and 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?

Krishni Thuraiarajah, MBChB, DFFP
General Practitioner, Airthyne Park Medical Centre, Hermitage Road, University of Stirling, Stirling FK9 4MJ, UK. E-mail: krishni.thuraiarajah@gp25559.forth-hb.scot.nhs.uk

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Full-term pregnancy with Implanon\(^{\text{TM}}\) in situ

I read with interest the letter in the July 2006 issue of the Journal regarding a successful full-term pregnancy with Implanon\(^{\text{TM}}\) in situ.\(^2\) I too have a patient who presented in similar circumstances and is continuing her pregnancy with Implanon\(^{\text{TM}}\) 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.

Elaine B Melrose, MD, FRCOG
Consultant Obstetrician and Gynaecologist, Crosshouse Hospital, Kilmarnock KA2 0BE, UK. E-mail: elaine.melrose@aaahc.scot.nhs.uk

References

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Full-term pregnancy with Implanon\(^{\text{TM}}\) in situ

The case of the full-term pregnancy with Implanon\(^{\text{TM}}\) in situ reported by Drs Cooling and Pauli in a recent issue of this Journal\(^3\) 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 “progestogens in pregnancy have not been linked with fetal abnormality”\(^4\) and applies only to low-dose progestogen. High doses (>10 mg per day of norethisterone or equivalent) has been associated with masculinisation in male human and hypospadias in the male fetus.\(^5\) It is accepted that the dose of progestogen released by Implanon is low at 40 mg per day. Therefore it is unlikely that the third trimester of Implanon insertion. The case in question is unique in that the Implanon was inserted after the critical period of organogenesis (i.e. 10–12 weeks’ gestation) when the susceptibility to teratogenic insults starts to decline. This is also the period when the luteo-placental shift becomes complete,\(^6\) so that the placenta is now capable of detoxification. Thus, in case described, the Implanon was effectively rendered inert, and its safety in this case cannot be extrapolated to Implanon in early pregnancy. Pregnancy would continue to remain an absolute contraindication to Implanon insertion.

Fourth, status quo. The option of leaving the Implanon in situ has hardly any benefits apart from sparing the patient the minor inconvenience of manual removal and possible negligible cost savings. Furthermore, the reason for the patient’s satisfaction with Implanon needs to be explored. For example, the amenorrhoeic state may be incidental on the pregnancy and not the Implanon. Hence, the patient’s current experience with Implanon may not be predictive of her future response to the device.

Fifth, primam non nocere. It would seem biologically plausible that although low-dose progestogens have not proved to be teratogenic, zero exposure to exogenous progestogens would be the safest approach. Thus, the option of removing the Implanon would eliminate the potential for adverse effects.

Recommendation. The absence of a clear benefit coupled with a potential for harm would encourage me to advise the patient to remove the Implanon. However, if after a full explanation of the implications she decides otherwise, I would support her choice and support her through the pregnancy.

Postscript. A very anti lapse afternoon urine sample could possibly explain the negative pregnancy test on the day of Implanon fitting. The initial pregnancy test could have been negative simply because it was too early: less than 3 weeks since the onset of pregnancy.

Parivakkam S Arunakumari, MD, MRCOG
Specialist Registrar, Obstetrics and Gynaecology, The Chilterns, Southmead Hospital, Bristol BS10 5NB, UK. E-mail: aruna2805@yahoo.co.uk

References

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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\(^{\text{TM}}\) was inserted when the patient was 12 weeks pregnant (i.e. 6 weeks after conception). This means, however, that organogenesis would not have been completed by the time the implant was inserted.

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...