References

Reply
We welcome the response by Lee et al. which is a valuable contribution towards the management of translocated intrauterine devices (IUDs). Lee et al. referred to the series of three cases described by Markovitch et al. These patients did not develop any complications resulting from the translocated IUD. Markovitch et al. clearly describe the circumstances under which conservative management of translocated IUDs is possible and also express the need for additional studies peripersonal reactions.

The WHO3 and Faculty of Sexual and Reproductive Healthcare4 guidelines recommend removing the IUD, particularly the copper ones, as soon as is reasonable possible. The problem with not following these guidelines is the unpredictability of the migration of the IUD and the associated outcome.

Lee and colleagues5 describes a case history of a patient using a Copper-7® IUD who remained asymptomatic for 2 years despite the device being translocated to the sigmoid colon without any evidence of intra-abdominal adhesions or sepsis. The remote possibility of catastrophic events cannot be ruled out. Robinson6 describes an asymptomatic patient at serious risk from catastrophic rupture of the superior mesenteric artery by a translocated Copper-7 device. Avni et al.7 studied the peritoneal reaction to copper devices in female albino rats. They found that the copper device group developed severe adhesions and consequently they recommended removal to minimise the harmful effects of copper. It is unclear to what extent the advice given by Lee et al. can be applied to humans.

In the absence of a tool to assess the risk, we recommend adhering to the WHO and Faculty of Family Planning guidelines.

We would welcome further discussion of this topic.

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References

Training for the LoC IUT
I read Dr Siddiqui’s letter1 in the January 2008 issue of the Journal with interest. The introduction of the copper IUD, which came from the same group of experts who have each independently developed their own ways of locating and removing implants,2 is to be of some value. This article arose out of extensive discussion with a group of experts who have each independently developed their own ways of locating and removing implants that are not covered by this article. We are trying to ensure that most of their practical tips on localisation were highlighted in this article.

Fortunately, deep insertions of Implanon® are uncommon, but all family planners, general practitioners, gynaecologists and general surgeons need to be aware that they may occasionally be faced with a patient requiring removal of an implant which cannot be palpated. Knowledge that an effective recommended strategy for management exists (and that specific expert advice is available, if required) should help to minimise some of the challenges encountered during difficult localisation and removal.

Dr Abyesundra may also be interested to see the review appearing in this issue of the Journal, which comes from the same group of experienced colleagues and specifically addresses the use of removal of deep implants.3 We hope that this will also help to minimise complications sometimes encountered in attempts at these procedures.

References

Implanon insertion in Zimbabwe
Recently in a family planning session, a 32-year-old Zimbabwean female presented for an Implanon® removal. The patient was insistent that she had had Implanon inserted and that the procedure had involved two rods and that she had been advised that this would last for 5 years. On palpation, two rods could be felt in different planes in the left upper arm but it was difficult to decipher whether these were one rod divided in two or two separate intact rods. On further enquiry from the patient, we were advised that it was common practice for two rods to be inserted at a medical practice in Zimbabwe, and that patients had been advised that duration was 5 years. The patient had not experienced any adverse effects and had decided to have the Implanon removed so that she could become pregnant.

It would be interesting to know whether the above is a true representation of Implanon insertion in Zimbabwe and, if so, whether this is an indication of training needs or whether there appears to be a misconception that two rods must in combination provide greater contraceptive cover than one, in light of previous use of Norplant®.

We would be grateful for any feedback from doctors.

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