Letters to the editor

References
3. Faculty of Family Planning and Reproductive Health Care. Contraception and Sexual Health Service. Newcastle upon Tyne Primary Care Trust, Newcastle-upon-Tyne, UK. E-mail: Diana.Mansour@newcastle-pct.nhs.uk

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 misplaced IUD. Markovitch et al. clearly describe the circumstances under which conservative management of translocated IUDs is possible and also express the need for additional conservative management of translocated IUDs.

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

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Reproductive Health Care, Lincoln, UK. E-mail: devonald@btinternet.com

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 and was interested in the response to my letter2 in the October 2007 issue. It was unfortunate that Dr Siddiqui’s letter was submitted too close to the press deadline to allow sufficient time for me to respond to her letter in the same issue of the Journal.

Dr Siddiqui does not seem to have understood my point. I was not saying that we should not fit copper intrauterine devices (IUDs) and I am happy to do so if women request them. My point, which Dr Siddiqui accepts, was that most general practitioners (GPs) will only fit the intrtraceptive system (IUS) (Mirena®) and if we insist that they must fit a copper IUD to obtain their Letter of Competence (LoC) then most of them will not be able to train. Most general practitioners do not have the facility to do all IUD fitting and many family planning clinics are under threat. We do need GPs to fit IUDs, both for contraception and also for the treatment of menorrhagia. If we do not allow them to obtain the LoC then they will stop fitting IUDs/IUS. This will not benefit patients. It is difficult for doctors who wish to train to obtain the necessary experience; we do not need to make it more difficult.

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References

Localisation of non-palpable implants

I read the article by Mansour et al. on methods of accurate localisation of non-palpable subdermal implants in the January 2008 issue of the Journal with great interest. I agree that alongside my own growing experience of implant insertions follows the request for removals. Identifying the insertion errors and unusual anatomical sites of the implant was particularly interesting. The authors’ suggestion that some experts use local anaesthetic to separate the tissue planes was a good tip. This has helped separate tissue planes that were more difficult to feel and less pathological removal. I also liked the simple advice of asking the patient where the implant was inserted and seeing the scar.

All in all a very valuable piece of reading! Thank you.

Melanie Ayesubanda, MBBS, BSc, FRCGP Registrar, Lawn End Medical Practice, Farriers Green, Lawley Bank, Telford TF4 2LL, UK

Reference

Reply

We were pleased to hear that Dr Ayesubanda1 found our study on the importance of non-palpable subdermal implants2 to be of some value. This arose out of extensive discussion within a group of experts who have each independently developed their own ways of locating and removing implants that are not readily palpable. We have also tried 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 Ayesubanda 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 issue of removal of deep implants.1 We hope that this will also help to minimise complications sometimes encountered in attempts at these procedures.

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Implanon insertion in Zimbabwe

Recently in a family planning session, a 52-year-old Zimbabwean female presented for an Implanon® removal. The patient was insistence 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 determine whether whether these were one rod divided in two or two separate Implanon rods. On referral to the hospital, two were found to be two separate intact Implanon devices.

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 indicator of training needs or whether there appears to be a misconception that two rods must in combination provide greater contraceptive cover than one rod of Implanon®

We would be grateful for any feedback from readers.

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