

References

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Reply

We welcome the response by Lee *et al.*,<sup>1</sup> 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.*<sup>2</sup> 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 study of peritoneal reactions.

The WHO<sup>3</sup> and Faculty of Sexual and Reproductive Healthcare<sup>4</sup> 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.

Beard<sup>5</sup> describes a case history of a patient using a Copper-7<sup>®</sup> 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. Robinson<sup>6</sup> describes an asymptomatic patient at serious risk from catastrophic rupture of the superior mesenteric artery by a translocated Copper-7 device.

Avni *et al.*<sup>7</sup> studied the peritoneal reaction to copper devices in female albino rats. They found that 90% of the rats in 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 these findings 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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Training for the LoC IUT

I read Dr Siddiqui's letter<sup>1</sup> in the January 2008 issue of the Journal written in response to my letter<sup>2</sup> 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 intrauterine system (IUS) (Mirena<sup>®</sup>) 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 hospitals 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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Localisation of non-palpable implants

I read the article by Mansour *et al.*<sup>1</sup> 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 sitings 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 thus facilitating less painful subcutaneous 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.

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Reply

We were pleased to hear that Dr Abeysondera<sup>1</sup> found our article on localisation of non-palpable subdermal implants<sup>2</sup> to be of some value. This article 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 palpable. The experts have tried to ensure that most of their practical tips on localisation were highlighted in this article.

Fortunately, deep insertions of Implanon<sup>®</sup> 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 Abeysondera 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.<sup>3</sup> 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 32-year-old Zimbabwean female presented for an Implanon<sup>®</sup> 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 rods. Upon removal, they 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 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<sup>®</sup>.

We would be grateful for any feedback from readers.

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