Letters to the editor


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.2 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 and research.

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.

Markovitch et al.5 described 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 translocated 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. The harmful effects of copper. It is unclear to what extent these findings can be applied to humans.

Jatti et al.8 found one of the cases of non-palpable subdermal implants2 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 mislocated. We were pleased to hear this approach is being adopted. The copper intrauterine device as long-term contraception. J Fam Plan Reprod Health Care 2004; 30: 29–42.

Jatti et al.8 suggested that some experts use local anaesthetic to separate the tissue planes was a good tip. This has helped separate the 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 the implant that cannot be palpated, particularly the copper ones, from deep intramuscular implants by palpation, two rods could be felt in different planes. The presence of two rods could be felt in different planes. The presence of two rods could be felt in different planes, although we were unable to identify two separate rods on palpation, as claimed by the authors. Robinson et al.8 described the peritoneal reaction to the translocated copper intrauterine device in women and female rats. Fertil Steril 1983; 39: 193–198.

Training for the LoC IUT

I read Dr Siddiqui’s letter1 in the January 2008 issue of the Journal. We were pleased to hear that Dr Siddiqui’s letter1 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 intraretinal 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 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 not 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 it to make it more difficult.

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Localisation of non-palpable implants

I read the article by Mansour et al.1 on methods of accurate localisation of non-palpable subdermal implants in the January 2008 issue of the Journal with 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 the implant that cannot be palpated, particularly the copper ones, from deep intramuscular implants. The patient was insistent on September 13, 2023 by guest. Protected by copyright.http://jfprhc.bmj.com/ J Fam Plann Reprod Health Care: first published as 10.1783/jfp.34.2.136e on 1 April 2008. Downloaded from on 1 April 2008. J Fam Plann Reprod Health Care: first published as 10.1783/jfp.34.2.136e on 1 April 2008. Downloaded from

References


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 rods. After a second attempt at removal, they were found to be two separate intact Implanon devices.

On further enquiry from the patient, we were advised that this 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 rod (as previously recommended by Norplant®). We would be grateful for any feedback from readers.