Introduction
Over the last 2 years this Journal has seen a flurry of papers and resulting correspondence related to ‘deep’ Implanon® insertion.1–7 More than 3 million women use etonogestrel contraceptive implants worldwide and 180 000 implants are fitted in the UK each year, with these numbers escalating as I write. From post-marketing data the reported rate of complex removal problems is low, running at about 1 per 1000 insertions. However, for a woman suffering nuisance side effects or wanting to become pregnant, this situation is frustrating and, for some, completely intolerable.

What improvements have been achieved to date in contraceptive implant provision? A number of meetings have been held with worldwide contraceptive implant ‘experts’. Discussions have focused on the anatomical site for fitting contraceptive implants, the complications associated with insertion, and techniques for removal of deep and often ‘non-palpable’ implants. Dissemination of these discussions has taken place5,8 and the manufacturing company agreed to alter the insertion site instructions, bringing them more in line with the levonorgestrel multi-rod implants, Norplant® and Jadelle®. The Summary of Product Characteristics (SPC) for Implanon now reads:8 ‘To minimise risk of neural or vascular damage, Implanon should be inserted at the inner side of the non-dominant upper arm about 8–10 cm above the medial epicondyle of the humerus’.

It is surprising that some senior clinicians have misinterpreted this information and have either thought Implanon should be inserted on the under surface of the arm or over the triceps. There has also been concern that some health care professionals are no longer fitting Implanon as they are confused about these new instructions. Very little has changed. The insertion site can now be moved out of the sulcus between the biceps and triceps (‘Tiger Country’ for ‘deep implant remover’)9 and many choose to insert it subdermally over the biceps on the anterior side of the non-dominant arm.10 Those who wish to insert Implanon in the sulcus may continue to do so as the SPC advice does not contraindicate this.

Specialist centres for implant removal
Whose responsibility is it to provide a regional referral service for the removal of deep, ‘non-palpable’ contraceptive implants? With the publication of the National Institute for Health and Clinical Effectiveness guideline covering long-acting reversible contraceptives (LARCs)11 and the roll-out of local LARC initiatives countrywide encouraging increasing use of contraceptive implants, Strategic Health Authorities (SHAs), Health Boards and health care commissioners must support and release funding to establish regional services for location and removal of deep contraceptive implants. The onus should not be placed at the doors of the pharmaceutical industry to manage a clinical complication resulting from incorrect insertion.

A number of UK regional referral sites have been established to locate and remove deep, impalpable contraceptive implants (Table 1). These centres all have an ultrasound machine to localise implants, and have some experience of removing deeply placed implants. For those interested in providing this service there have been some important lessons learnt by many of the ‘expert’ removers.

First, a business plan should be submitted to those holding the purse strings and a service level agreement with additional funding agreed. This is particularly important for women who are referred from neighbouring SHA regions. It is also important that all the ‘expert’ centres now develop appropriate pathways to deal with those deeply placed implants that they cannot remove.

Second, it must be remembered that most ‘deep’ implants result from poor insertion technique by health care professionals. Women referred to ‘specialist’ centres are frequently unhappy with their care and may have waited significant lengths of time to be seen. If possible the location and removal should take place on the same day, especially if women have travelled long distances. Ideally there need to be two trained health care professionals who can remove ‘deep’ implants in the service to cover annual, study and sick leave. Careful documentation of all referred cases is essential as occasionally these are subject of a complaint or litigation. The health care professional who inserted the non-palpable implant should be informed and, if there are repeated events, the lead clinician within the primary care organisation or hospital should be contacted to ensure that no further implants are inserted by this person until supervised retraining has taken place. Women with non-palpable implants are an ‘adverse event’ and should be reported via the local risk management process and anonymously to Organon Laboratories, part of the Schering-Plough Corporation.

To maintain surgical skills the health care professional should remove at least 12 ‘deep’ implants each year (one a month). Consequently there is little point setting up a service – with significant upfront costs for surgical and ultrasound equipment – if few women will be seen.

Conclusions
Organon Laboratories have been most responsible in supporting contraceptive implant theoretical and practical training. They have also supported the development of the referral centres through education and training. It is now time for the company to allow the National Health Service to realise its responsibilities. In England the Department of Health has allocated £26.8 million of additional money to local primary care organisations and SHAs to improve access to contraception.12 Those holding that money should use it wisely and appropriately, making sure that their population has quality contraceptive provision including referral pathways for ‘expert’ help. Unfortunately, at the time of writing this article, this primary care organisation allocation is still a ‘well-kept
secret; thus few clinicians or service managers have been able to submit business plans, resulting in delays to service development. This situation needs to be addressed, and as soon as possible.

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**References**


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