Comment on ‘Continuing need for and provision of a service for non-standard implant removal’: authors’ response

We thank Drs Bacon and Mahfoud for their comments1 on our article2 that appeared in the April 2014 Journal.

We do use the U-technique with subfascial implants. The ultrasound equipment we had access to at the time of data collection necessitated a compromise of using a low-frequency transducer (suitable for deeper structures) on a setting for musculoskeletal imaging. This enabled visualisation of the implant, but unless it was deep in muscle the image was often not of sufficient resolution to establish whether the implant was above or below the fascia. We now have a higher specification machine with a high-frequency linear transducer, which provides clear definition of the anatomy.

We have noticed that implants above the fascia can usually be felt, even when placed deep in subcutaneous fat. Palpation is facilitated by using imaging to clarify exactly where to press to elevate one end of the implant to a palpable level. When the implant is below the fascia depresssing one end will not render it palpable, even in very thin women. However, we find that the vast majority of definitively non-palpable implants can rapidly be removed with ring forceps through a 3 mm incision. We would use the longer incision (just long enough to insert the tip of a finger to then palpate the implant) when the implant is very close to a nerve or a blood vessel. This is necessary in only a small minority of referred cases.

We have noted a possible trend in that there seems to be a high proportion of deep and/or migrated cases where the implant was refitted through a removal site. We wonder whether the dissection for removal around this point and existence of an unhealed implant track may predispose to deep replacement.

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Competing interests None.

REFERENCES