

to the medial intermuscular septum of the upper arm.

The needle of the device is now advanced in the tunnel of local anaesthetic while again tenting the skin, thereby avoiding damage to underlying structures. The need for tenting also ensures that the container of the implant is always held parallel to the skin during advancement.

Finally, tenting provides assurance that not only is one in the subdermal plane but that insertion into the dermis is avoided.

I have not encountered difficulty with palpating the length of the implant and its ends following the procedure described.

Non-deployment of the implant is likely to arise from failure to follow recommended procedure and some lack of appreciation of the anatomy of the region.

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## REFERENCE

- 1 Walling M. Inserting the etonogestrel contraceptive implant. *J Fam Plann Reprod Health Care* 2016;42:75.

## Comment on 'Inserting the etonogestrel contraceptive implant'

Martyn Walling's letter<sup>1</sup> about insertion of Nexplanon<sup>®</sup> describes a technique that is at some variance with the method recommended by the manufacturer of the implant.

I believe that there is merit in depositing local anaesthetic under skin as a tunnel, as this step helps separate skin from the underlying deep fascia and opens the plane in which the implant would eventually lie. Tenting skin during advancement of the local anaesthetic needle is an additional step in this process. The essential safety of this step is that one avoids damage to the medial cutaneous nerve of the forearm and the ulnar nerve which is posterior