Nexplanon® removals in a community sexual and reproductive health service

The subdermal implant is an efficacious, cost-effective method of long-acting reversible contraception with an excellent safety profile,[1] favourably evaluated by the National Institute for Health and Care Excellence.[2] Yet, amongst health care professionals and patients alike there remain obstacles to its uptake. There is often a degree of reticence or reluctance in both promotion and uptake based on perceptions of high removal rates or poor tolerance, especially to nuisance bleeding.[3 4]

I performed a review to investigate the seemingly high removal rate within our community sexual and reproductive health service in Yorkshire, UK. Our service serves a population with a broad demographic across both urban and semi-rural areas, with 28 000 contacts annually.

I reviewed the notes of all patients who attended for Nexplanon® removal between 1 October and 31 December 2013 to collect data on length of use, place of fitting, reason for removal, and future contraception. Evidence of medical intervention being offered to deal with nuisance side effects[5] was noted. Where this was offered, data were collected on what intervention had been offered.

The initial database search reported 282 removals between 1 October and 31 December 2013. The number of subdermal implant fittings during this period was 294.

The patients' age ranged from 15 to 52 years, with a mean age of 26.0 years.

The average length of use was 2 years 3 months, with a range from 2 weeks to a maximum of 8 years. In total this represented 588 years of Nexplanon use.

The majority of fittings were performed within the contraception and sexual health facility (118), though a significant number were fitted in general practice (40) and a small number at termination of pregnancy (18). Place of fitting was not documented in 106 records.

The majority of removals were due to expiry of device (Figure 1), with bleeding problems being the next most common reason, followed by removal requested by patients wishing to try to conceive. One patient attending for removal turned out to have conceived after expiry of the device, and decided to continue with their pregnancy. Mood change, weight gain and pain at the insertion site were also quoted as reasons for removal. Less common reasons were acne, headache, amenorrhoea, allergy, breast tenderness, lack of libido, and celibacy.

Where the reason for removal was nuisance bleeding, an offer of medical management was not documented in most (75) cases. Forty-five patients were offered and accepted medical management, and eight patients were offered an intervention but declined.

The most common intervention was the combined oral contraceptive pill (COC) (27), the majority being levonorgestrel-containing pills (Microgynon®/Levest®) (20). Fifteen patients were offered a progestogen-only pill (POP), and of these 13 were prescribed desogestrel (Cerazette®/Cerelle®). Other treatments were norethisterone (3), mefenamic acid (1), tranexamic acid (1) and Depo-Provera® (1).

The most common form of contraception used following removal was a further Nexplanon (83), followed by a desogestrel POP (48), COC (44), condoms (18), Depo-Provera (13), Mirena® intrauterine system (9), Evra® combined transdermal patch or an intrauterine device (6). Fifty-six patients declined any form of ongoing contraception.

While the results of the initial database search seem to represent a high removal rate, the average length of use for the current device was 2 years 3 months, reflecting favourably on continuity.

The majority of removals were due to expiry of the device and many were to regain fertility. Fewer removals were due to patient dissatisfaction or poor tolerance.

The majority of patients chose a further Nexplanon for ongoing contraception, which supports a conclusion of high levels of user satisfaction in this group.

Medical management was not offered to a significant number of patients with nuisance bleeding, which is an area for potential improvement. Such intervention may help improve tolerance, prevent or delay removal, and lead to improved continuity rates. Greater awareness and confidence in prescribing could improve these outcomes.

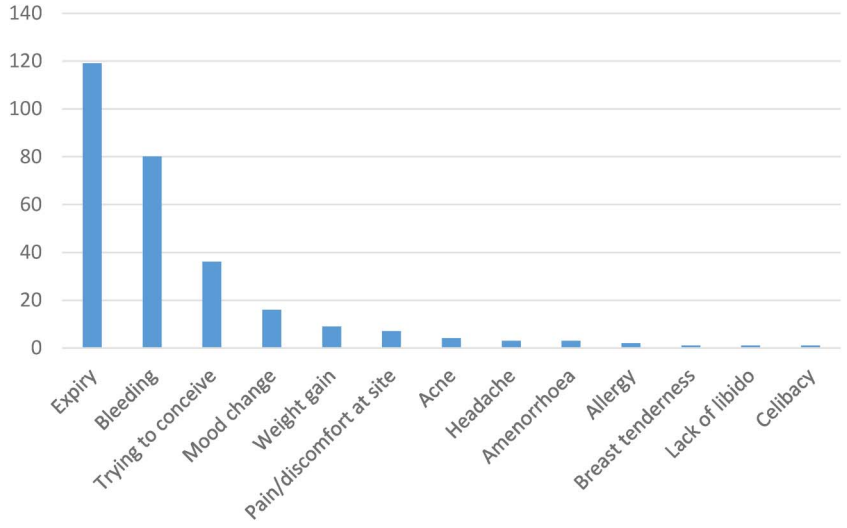

Figure 1 Reasons for subdermal contraceptive implant removal in a community sexual and reproductive health service.

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