

seen and that it should then be advanced parallel to the skin.<sup>2</sup> This will minimise deep insertions as sometimes the skin can be tough, and when the needle is passed through the skin the tissues can sometimes 'give' and the needle end up further below the dermis than intended, resulting in a deep insertion.

My concern is two-fold. First, 'freezing' the skin could possibly make the skin tougher to penetrate, hence leading to a deep insertion. Second, because one has to be very quick with inserting the implant before the effect of the spray wears off, one may be more inclined to insert deeply due to having to work fast and not having the time to pull back the bevel slightly. With lidocaine you do not have to be very fast and you can spend a bit of time making sure the implant is fitted subdermally. Of course the disadvantage of lidocaine is that the patient has to have an injection, which can be a problem with needle-phobic patients. Conversely, it will be less traumatic for patients when they return for implant removal or change if the implant is fitted correctly and subdermally.

This has only been an observation on my part at our clinic, and I hope to record future data to see if there is any correlation between the use of ethyl chloride spray and the deep insertion of implants. I therefore also wonder if any other clinicians have observed this phenomenon?

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## Deep implant insertions and ethyl chloride

The use of ethyl chloride to anaesthetise the skin by cooling before implant insertion has been used and documented previously.<sup>1</sup> I was trained to remove deep implants by the very experienced Dr Martyn Walling, but have observed over the last few months that some of the deep fittings have included the use of ethyl chloride as anaesthetic prior to insertion. Dr Walling taught me that once the bevel of the implant needle is inserted through the dermis, it should then be withdrawn until the bevel is just