Letters to the editor

References

Training for the LoC IUT

I read Dr Siddiqi’s letter1 in the January 2008 issue of this Journal with great interest. I agree that the insertion of IUDs follows the request for removals. Alongside my own growing experience of implant removals, I am happy to do so if women request them. My point, which Dr Siddiqi accepts, was that most general practitioners (GPs) will only fit the intrauterine system (IUS) (Mirena®) and if we insist that they must fit a copper IUD to obtain their Letter of Competence (LoC) then most of them will not be able to train. Most general hospitals do not have the facility to do all IUD fitting and many family planning clinics are under threat. We do need GPs to fit IUDs, both for contraception and also for the treatment of menorrhagia. If we do not allow them to obtain the LoC then they will not stop fitting IUDs/IUS. This will not benefit patients. It is difficult for doctors who wish to train to obtain the necessary experience; we do not need it to make more difficult.

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References

Localization of non-palpable implants

I read the article by Mansour et al.1 on methods of accurate localisation of non-palpable subdermal implants in the January 2008 issue of the Journal with great interest. I agree that alongside my own growing experience of implant insertions follows the request for removals. Identifying the insertion errors and unusual anatomical samplings of the implant was particularly interesting. The authors’ suggestion that some experts use local anaesthetic to separate the tissue planes was a good tip. This has helped separate the tissue planes in the left upper arm but it was difficult to palpate the implant. The authors’ suggestion that some experts use local anaesthetic to separate the tissue planes was a good tip. I also found it difficult to palpate the implant. I agreed that the procedure had involved two rods and that she had palpated the two rods. In the absence of a tool to assess the risk, we recommend adhering to the WHO and Faculty of Family Planning guidelines.

We would welcome further discussion of this topic.

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References

Replay

We were pleased to hear that Dr Abeysundera1 had found our report on the removal of non-palpable subdermal implants2 to be of some value. This article arose out of extensive discussion within a group of experts who have each independently developed their own ways of locating and removing implants that are not palpable. Many of these experts have tried to ensure that most of their practical tips on localisation were highlighted in this article.

Fortunately, deep insertions of Implanon® are uncommon, but all family planners, general practitioners, gynaecologists and general surgeons need to be aware that they may occasionally be faced with a patient requiring removal of an implant which cannot be palpated. Knowledge that an effective recommended strategy for management exists (and that specific expert advice is available, if required) should help to minimise some of the challenges encountered during difficult localisation and removal.

Dr Abeysundera may also be interested to see the review appearing in this issue of the Journal, which comes from the same group of experienced colleagues and specifically addresses the issue of removal of deep implants.3 We hope that this will also help to minimise complications sometimes encountered in attempts at these procedures.

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References

Implanon insertion in Zimbabwe

Recently in a family planning session, a 32-year-old Zimbabwean female presented for an Implanon® removal. The patient was insisted that she had had Implanon inserted and that the procedure had involved two rods and that she had been advised that this would last for 5 years. On palpation, two rods could be felt in different planes in the left upper arm but it was difficult to deciper whether these were one rod divided in two or two separate devional removal, they were found to be two separate intact Implanton devices.

On further enquiry from the patient, we were advised that it was common practice for two rods to be inserted at a medical practice in Zimbabwe, and that patients had been advised that duration was 5 years. The patient had not experienced any adverse effects and had decided to have the Implanon removed so that she could become pregnant.

It would be interesting to know whether the above is a true representation of Implanon insertion in Zimbabwe and, if so, whether this is an indication of training needs or whether there appears to be a misconception that two rods must in combination provide greater contraceptive cover than one rod alone (Norplant®).

We would be grateful for any feedback from readers.

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