Letters to the editor

References

Reply
We welcome the response by Lee et al., which is a valuable contribution towards the management of translocated intrauterine devices (IUDs).

Lee et al. referred to the series of three cases described by Markovitch et al. These patients did not develop any complications resulting from the translocated IUD. Markovitch et al. clearly describe the circumstances under which conservative management of translocated IUDs is possible and also express the need for additional study in this rare condition.

The WHO3 and Faculty of Sexual and Reproductive Healthcare guidelines recommend removing IUD, particularly the copper ones, as soon as is reasonably possible. The problem with not following these guidelines is the unpredictability of the migration of the IUD and the associated outcome.

Robinson6 describes a case history of a patient using a Copper-7® IUD who remained asymptomatic for 2 years despite the device being translocated to the sigmoid colon without any evidence of intra-abdominal adhesions or sepsis. The remote possibility of catastrophic events cannot be ruled out. Robinson6 describes an asymptomatic patient at serious risk from catastrophic rupture of the superior mesenteric artery by a translocated Copper-7 device. Avni et al.7 studied the peritoneal reaction to copper devices in female albino rats. They found that the copper bipolar device developed severe adhesions and consequently they recommended removal to minimise the harmful effects of copper. It is unclear to what extent these results can be applied to humans.

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

Training for the LoC IUT
I read Dr Siddiqui’s letter1 in the January 2008 issue of this journal. She was unable to respond to my letter2 in the October 2007 issue. It was unfortunate that Dr Siddiqui’s letter was submitted too close to the press deadline to allow sufficient time for me to respond to her letter in the same issue of the Journal.

Dr Siddiqui does not seem to have understood my point. I was not saying that we should not fit copper intrauterine devices (IUDs) and I am happy to do so if women request them. My point, which Dr Siddiqui accepted, was that most general practitioners (GPs) will only fit the intrauterine system (IUS) (Mirena®)1 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 fit 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 to make it more difficult.

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References

Localisation 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 considerable interest. I agree that alongside my own growing experience of implant insertions follows the request for removals. Identifying the insertion errors and unusual anatomical sites of the implant was particularly interesting. The authors1 suggested that some experts use local anaesthetic to separate the tissue planes in the left upper arm but it was difficult to decipher whether these were one rod divided in two or two separate depositions, both of which were found to be two separate intact Implanon® 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 single device (Norplant®).2

We would be grateful for any feedback from readers.

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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 insistent 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 decipher whether these were one rod divided in two or two separate depositions, both of which were found to be two separate intact Implanon 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 single device (Norplant®).

We would be grateful for any feedback from readers.

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Reply

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