

Simultaneous Removal of Two Impalpable Etonogestrel-68mg (Implanon-NXT™) Implants from the Left Arm: A Case Report

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Abstract

Background: The etonogestrel-releasing implant is a long-acting reversible contraceptive method with proven contraceptive and therapeutic efficacy. Providers need to know how to insert and remove it and also should be aware of its mechanism and length of time of action.

Case Presentation: We report on a case of a 46-year-old woman who had two impalpable implants in different positions of the left upper arm. They had been placed 3 years apart in the designated sites at the time. They were easily removed following ultrasound mapping and a new subdermal one placed.

Conclusion: This case highlights the two main problems associated with all long-acting reversible contraceptive technologies, namely, adequate technical expertise and secondly a reasonable understanding of the manner and length of duration of action of the method. These two attributes are essential for the successful use of implant and other long-acting reversible contraceptive use. The problem of being unable to remove an implant should not be compounded by inserting a second one, especially if also cannot be easily removed.

Keywords: Implant, Nexplanon, Deep, Removal, Case Report.

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Introduction

The etonogestrel releasing implant is a long-acting reversible contraceptive (LARC). The use of LARC methods of contraception have been shown to provide superior contraceptive protection in certain situations, however there are numerous barriers to its provision [1,2]. One of these barriers for implants is the difficulty of removing deep or impalpable implants in low resource settings such as ours. We get a number of deep and impalpable Implanon NXT™ /etonogestrel-68mg (ETN-68) requiring removal and also the occasional twin rod Jadelle™ (LNG-150mg) for removal They represent treatment failures.

We currently get about 10 referrals for 'deep' implants for removal per month and about 30% prove to be impalpable. Our clinic has removed about 2500 impalpable placings to

date, fortunately without a single significant adverse event to date. We recently reported on a patient who had an impalpable ETN-68 mg in both the left and the right arms which were successfully removed using ultrasound [3]. This report is of a patient who had two impalpable ETN-68 mg in the same arm, one in the previously recommended site above the bicipital groove and the second in the more recently recommended site on the inner side of the non-dominant upper arm, about 8-10 cm (3-4 inches) above the medial epicondyle of the humerus and 3-5 cm posterior to the sulcus (groove) between the biceps and triceps muscles. This report is to alert providers of the difficulty that can occur if implants are not inserted correctly and not to compound the problem. The protocol we followed is the same as for the previous report using the Sonoscan E5 at 12 MHZ with a focus at 0.5

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to 1.5 cm. The report follows the CARE guidelines and includes written consent from our patient [4].

Case Report

A 46-year-old woman was referred to us with two impalpable ETN-68mg implants in the left arm. She was P3G3 and had previously had two cesarean deliveries. The patient was moderately obese suggesting that the implants would be located in the adipose tissue above the fascia overlying the muscle. The first implant had been placed in 2019 and had “expired” in 2019. Accordingly, a second Implanon was placed (also incorrectly) with an apparent “expiry” date in March 2025. The subject had no co-morbidities and was amenorrhoeic and wanted to continue using this method of contraception.

Ultrasound scanning revealed the first implant above the bicipital groove in the adipose tissue (Figure 1). It was removed at the first attempt using a modified Walling-Mansour technique, after carefully mapping out its position. The arm was rescanned and the second implant was found in the more recently recommended position as described above (Figure 2) [5,6]. It was also removed at first attempt using the same method. Lignocaine 1% was used for analgesia. Both incisions were small enough to require closure with sterile strips without the need for sutures. Following removal of both implants a new implant was inserted via the second incision in a correct subdermal position. The location of the site of each implant is shown in Figure 3. We advised the patient to continue using the new implant for at least 5 years for its proven contraceptive benefit for this length of time, particularly at her age and for proven therapeutic benefits including bleeding and pain reduction and prevention of endometrial hyperplasia [7,8].



Figure 1: Ultrasound of the first implant in the bicipital groove ('old position') situated above the muscle fascia.

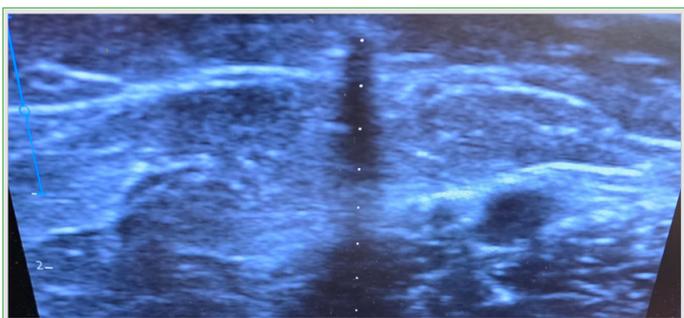


Figure 2: Ultrasound of the second implant in the lower position ('new position') also above the muscle fascia.



Figure 3: Sites of removal of the two impalpable implants.

Discussion

This report highlights the two perennial problems that providers of LARC face which are not seen with the provision of short acting contraceptives. Short acting methods only act for a short time and do not “expire” and whether they are pills or mechanical products the technical problems with their use comes from the user and not the provider.

The first problem providers of LARCs face are that of technical competence, for both implants and intrauterine devices. Our patient illustrates the technical problem associated with correct placement of the implant which creates the technical problem associated with subsequent removal. These problems limit the provision of LARCs because of the fear of creating and then having to deal with these problems. The second problem that providers face is that of knowing when to replace an existing LARC. The choice needs to be made between the manufacturer's recommendation (upon which the legal licence is usually based) and pharmacokinetics and pharmacodynamics of the product which will give a much better indication of when the efficacy of the product will truly expire. The serum etonogestrel levels for the ETN-68mg implant have been reported as being between 72-538 picograms/ml and even the lower level is close to the ovulation inhibition level (~ 90 pg/ml) let alone the other antifertility effects of this method, after 5 years of use. This knowledge could have prevented the hasty insertion of an incorrectly placed second implant before obtaining the appropriate method of response [8].

Conclusion

The provision of LARC contraceptive methods, including implants require both technical competence and some basic knowledge on how rationally or otherwise the length of time for which the product can be utilized is determined.

Ethical Approval

Ethical approval and written consent of the patient to publish was obtained.

Authorship

Both authors contributed equally

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Informed Consent

The patient gave written informed consent to publication

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