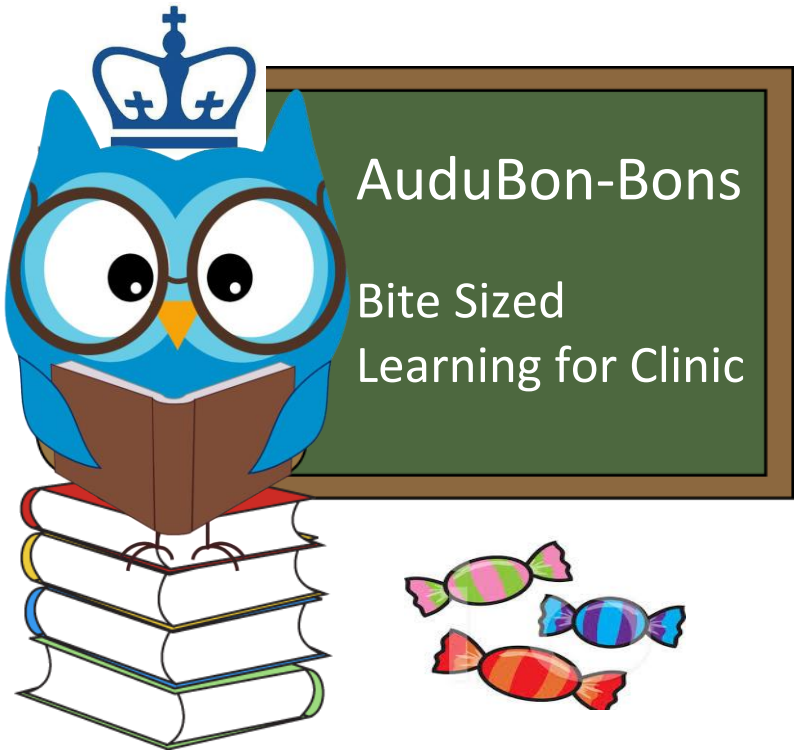
NEXPLANON REMOVAL



Week 56

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With SDH and .phrase slides by Chloé Altchek, MS4

Reading Assignment:
ACOG Practice Bulletin #186
Long-Acting Reversible Contraception: Implants and Intrauterine Devices

LEARNING OBJECTIVES

- To review the steps for safe removal of a palpable Nexplanon
- To be able to problem-solve challenges during Nexplanon removal
- To understand the management of a non-palpable Nexplanon

CASE VIGNETTE

- Ms. Listo Para Ninos, a 28 yo G0 woman, presents to clinic requesting removal of her Nexplanon implant, as she now desires to attempt conception.

FOCUSED HISTORY

What elements of this patient's history are most relevant?

- **PMH:** Resolved childhood asthma
- **PSH:** Adenoidectomy age 11
- **POBH:** Nulliparous
- **PGYNH:** Regular menses q28d x 3d
  LMP 1 week ago
  Nexplanon has been in place for 2 years in her left arm. She can palpate it.
  Sexually active with one mutually monogamous male partner. Does not use barrier protection.
- **MEDS:** Nexplanon
- **ALL:** Sulfa – rash

PERTINENT PHYSICAL EXAM FINDINGS

What elements of this patient's physical exam are most relevant?

- General: No acute distress, well appearing, normal vital signs, BMI 20
- **Ext: Warm, well perfused, normal in appearance, no edema, no rash. Left arm with Nexplanon palpable 8cm proximal from the medial epicondyle of the humerus, and 3cm posterior to the sulcus between the biceps and triceps muscles**

INFORMED CONSENT

What will you discuss with the patient before signing the consent form?

- Laterality
  - Needs to be documented on consent form

- Risks/ Benefits/ Alternatives
  - **Risks:** Bleeding, infection, discomfort during removal, hematoma, parethesias, scarring, incomplete removal of implant
  - **Benefits:** Cessation of contraception
  - **Alternative:** Keep Nexplanon in place

PRE-PROCEDURE CONSIDERATIONS

The MA asks what instruments/ supplies you will need in the room before you begin.

- Adequate lighting
- Chux
- Antiseptic solution (povidone-iodine or chlorhexidine)
- Surgical marker
- Local anesthetic, needles, syringe
- Sterile scalpel, forceps (straight and curved mosquito)
- Steri strips, sterile gauze, and pressure bandage

PROCEDURE

Describe the steps of the procedure

1. Conduct a NYP time-out.
2. Have patient lie on back with arm flexed at the elbow and externally rotated so that her hand is underneath her head.
3. Locate the implant by palpation. Push down the end of the implant closest to the shoulder to stabilize it; a bulge should appear indicating the tip of the implant that is closest to the elbow.

   If the tip does not pop up, removal of the implant should be performed by a provider experienced with removing deeper implants (Family Planning).

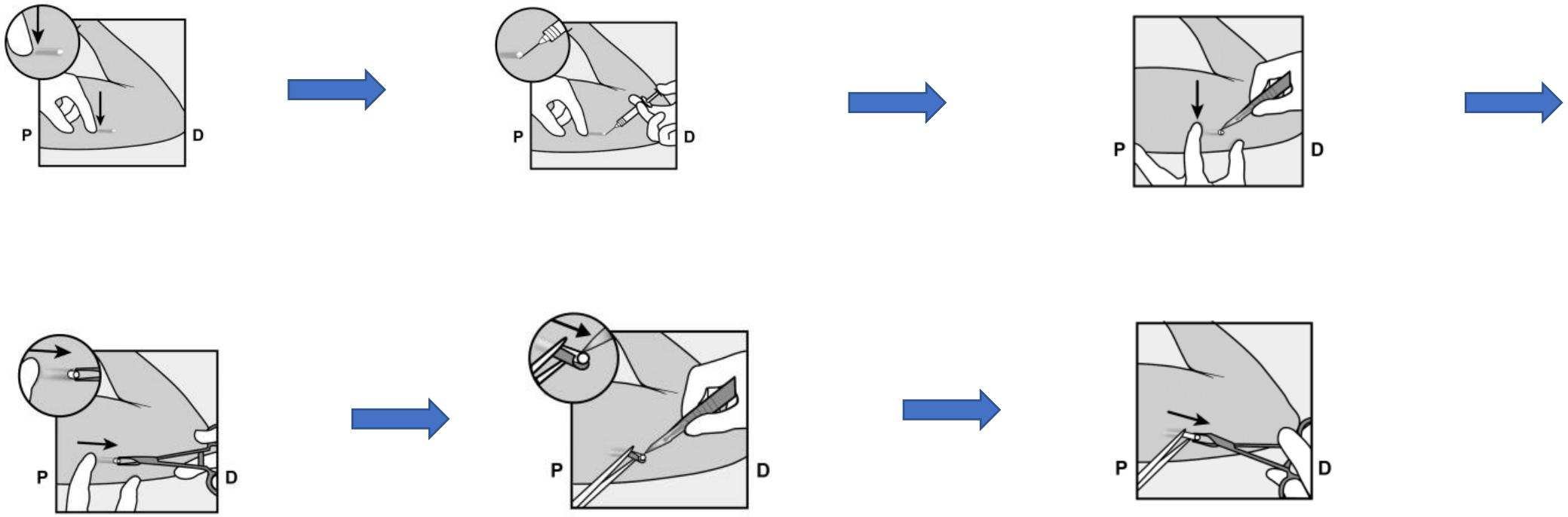
4. Mark the distal end with a surgical marker.
5. Clean the site with an antiseptic solution.
6. Anesthetize the site with 1mL 1% lidocaine where the incision will be made.

   Be sure to inject the lidocaine under the implant to keep the implant close to the skin's surface.

PROCEDURE

7. Push down the proximal end of the implant to stabilize it throughout the procedure. Starting over the distal tip, make a longitudinal incision about 2mm toward the elbow.
   - Take care not to cut the tip of the implant
8. The tip of the implant should pop out of the incision. If it does not, gently push the implant towards the incision until the tip is visible.
   - If needed, gently remove adherent tissue from the tip of the implant using blunt dissection. If that does not expose the implant tip, make an incision into the tissue sheath and then remove the implant with the forceps.
9. Grasp the implant with forceps, and if possible remove it.
10. Confirm the entire implant, which is 4cm long has been removed by measuring it.
11. Close the incision with a steri strip.
12. Apply a sterile gauze and pressure bandage to minimize bruising.
13. The patient may remove the pressure bandage in 24 hours and the steri strip in 3 to 5 days.

PROCEDURE

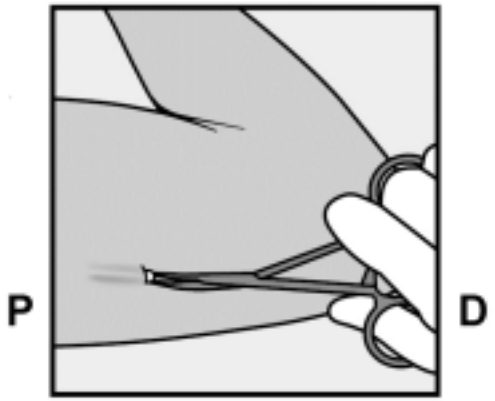


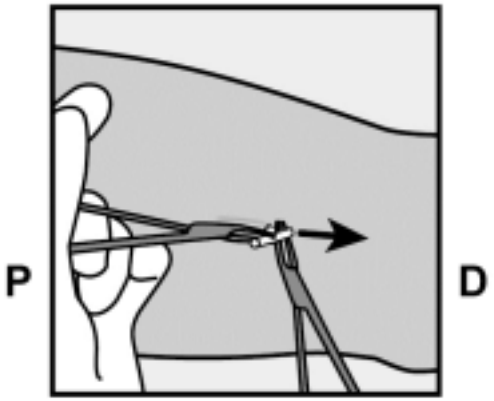
PROBLEM-SOLVING

What do you do if the tip of the implant does not become visible in the incision?

- Insert curved mosquito forceps with the tips pointed up superficially into the incision.
- Gently grasp the implant and flip the forceps over into your other hand.
- With a second pair of forceps, carefully dissect the tissue around the implant and grasp the implant.
- The implant can then be removed.
- If the implant cannot be grasped, stop the procedure and refer the patient to Family Planning.

PROBLEM-SOLVING





NON-PALPABLE IMPLANT

Should you attempt removal of a non-palpable implant?

- No, you must locate it prior to attempting removal

What is your first step if you cannot palpate the implant?

- Review the patient's Nexplanon user card or medical record to verify laterality of implant
- Palpate contralateral arm

What are the causes of non-palpable implants?

- Migration of implant or deep insertion

What imaging studies can be used to visualize the implant?

- X-ray, CT scan, Ultrasound, MRI

What if the Nexplanon still cannot be visualized?

- Consider imaging techniques of the chest as events of migration to the pulmonary vasculature have been reported
- Etonogestrel serum level can be used for verification of presence of Nexplanon

SOCIAL DETERMINANTS OF HEALTH

20% of SDIs are removed early (before 34 months)

 # 1 reason: increased frequency of menstrual bleeding

Others include: Irregular menstrual bleeding, weight gain, pain, depression, hair loss, headaches

Given that most* reasons are known side effects, pre-placement counseling regarding significant side effects could decrease early removal rates

* Studies have shown that Nexplanon use does not lead to weight gain

EPIC .PHRASE

.BBonNexplanonremovalcounseling

Description: Nexplanon removal counseling

The risks of Nexplanon removal were discussed, including pain, bruising, bleeding, infection, injury to surrounding structures, discomfort during removal, hematoma, paresthesias, scarring, incomplete removal of implant and inability to remove the Nexplanon. The benefit of cessation of contraception and the alternative of keeping Nexplanon in place were also discussed.

.BBonNexplanonremovalprocedure

Description: Nexplanon removal procedure

After obtaining consent and performing a timeout, the patient was positioned in supine position with her ***left arm flexed at the elbow. The incision site was marked and the area prepped with chlorhexidine. 1ml of 1% lidocaine was injected just below the skin of the planned incision site. A 2mm incision was made with a scalpel and the implant was removed without difficulty. The implant was noted to be intact. The area was cleaned and steri-strips placed over the incision site. A pressure dressing was applied and the patient was given all post-care instructions. The patient tolerated the procedure well.

CODING AND BILLING

Basic Contraceptive Implant Coding

The diagnostic coding will vary, but usually will be selected from the Z30.01- (encounter for initial prescription of contraceptives) and Z30.4- (encounter for surveillance of contraceptives) series in ICD-10-CM. These codes are:

Z30.017 Encounter for initial prescription of implantable subdermal contraceptive

This code is reported for the initial prescription, counseling, advice, and insertion of the implant, even when the insertion is performed at a separate encounter

Z30.46 Encounter for surveillance of implantable subdermal contraceptive

This code is reported for checking, reinsertion, or removal of the implant

The contraceptive implant is a single-rod etonogestrel-releasing contraceptive device inserted under the skin of the upper arm. The insertion and/or removal of the implant are reported using one of the following CPT (Current Procedural Terminology) codes:

11981 Insertion, non-biodegradable drug delivery implant

11982 Removal, non-biodegradable drug delivery implant

11983 Removal with reinsertion, non-biodegradable drug delivery implant

CPT procedure codes do not include the cost of the supply. Report the supply separately using a HCPCS (Healthcare Procedural Coding System) code:

J7307 Etonogestrel (contraceptive) implant system, including implant and supplies

EVIDENCE

References

- Long-Acting Reversible Contraception: Implants and Intrauterine Devices. ACOG Practice Bulletin No. 186. Obstet Gynecol 2017; 130:e251-69.
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- Anna Maria Teunissen, Bernd Grimm & Frans J. M. E. Roumen (2014) Continuation rates of the subdermal contraceptive Implanon® and associated influencing factors, The European Journal of Contraception & Reproductive Health Care, 19:1, 15-21, DOI: 10.3109/13625187.2013.862231
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- Dickerson LM, Diaz VA, Jordon J, et al. Satisfaction, early removal, and side effects associated with long-acting reversible contraception. Fam Med. 2013;45(10):701-707.