

been offered a diagnostic laparoscopy but defaulted and was unfortunately discharged at that stage. An active follow-up policy involving the patient's general practitioner could have prevented the later development of the multi-organ complex mass.

Cases of post-tubal occlusion salpingitis with involvement of the urogenital tract or the bowel have been described in the literature.<sup>7-9</sup> Migration of a clip can be associated with subacute inflammation. In the reported cases including this one, complications did not become apparent within 2 years of the sterilisation procedure. Tubal occlusion with clips does not prevent salpingitis.<sup>10</sup> In the present case, at the time of the laparoscopic clip sterilisation both tubes and ovaries appeared normal. It is debatable whether the second-trimester termination of pregnancy and evacuation of the uterus carried out 6 years earlier had been complicated by bacterial tubal colonisation leading to chronic salpingitis (the woman had received a course of metronidazole and cephalexin after her first operation) or if she had acquired a fresh infection. Biologically inert implants can become colonised with staphylococci and independently cause a foreign body reaction. We were unable to find an identical case to the present one from a MEDLINE search (to December 2005). However, in a related case<sup>4</sup> an inflammatory mass was diagnosed 3 years following laparoscopic sterilisation using Filshie clips undertaken 6 weeks postpartum. Pus was drained laparoscopically from an abscess involving a Fallopian tube, the bladder and anterior wall of the uterus. Abscess formation recurred within 9 months and was managed by incision and drainage from the anterior vaginal fornix when one clip was retrieved.

Legal abortion procedures and female sterilisation are among the most commonly undertaken surgical procedures in the UK. Laparoscopic tubal occlusion immediately following termination of pregnancy is sometimes considered in clinical practice when a woman with an unplanned pregnancy requests a sterilisation. There are no published data regarding its frequency but it is a not uncommon situation that occurs between an outpatient appointment and admission (Saha and Clausen, personal observation). In an audit of contraception following induced abortion in a district general hospital, 7/16 parous women aged  $\geq 25$  years requested immediate sterilisation following surgical termination of pregnancy (sample size  $n = 84$ ; Saha and Clausen, unpublished data, 1999). Although sterilisation procedures undertaken in the mid-

trimester are considered to have a low morbidity,<sup>11</sup> there are no published follow-up data. In a more recent study, an association with higher rates of failure as well as regret was found.<sup>12</sup> (NB. Filshie clips were not used in that population.)

The suspected presence of genital tract infection should be taken into account regarding the timing of the sterilisation procedure. The present case report highlights the need for awareness of the possibility of post-tubal occlusion salpingitis, which may manifest long after the procedure has been carried out. The applied clip can migrate with the nidus of infection and produce a complex inflammatory mass involving various vital structures. Such lesions may present years after the sterilisation procedure.

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## Book Review

**Oxford Handbook of Genitourinary Medicine, HIV and AIDS.** R Pattman, M Snow, P Handy, *et al.* (eds). New York, NY: Oxford University Press, 2005. ISBN: 0-19-852077-8. Price: £24.95. Pages: 551 (paperback)

The *Oxford Handbook of Genitourinary Medicine, HIV and AIDS* is the latest edition of the widely used Oxford Textbook Series. These provide inexpensive and portable reference guides for the management of conditions in a specific field. I reviewed the book from the perspective of both the experienced reader and those new to the speciality.

The handbook is divided into two main sections, those of genitourinary medicine (GUM) and HIV/AIDS. The format is pocketbook-sized, with a clear layout and space for additional note

taking. Also provided is a short picture atlas of commonly seen conditions in GUM and HIV.

The text is well written and presented, with numerous flow charts and tables for the practical management of common conditions. The full range of genitourinary sexual health is covered, ranging from clinical history taking and examination to genital dermatoses and psychosexual medicine. These were dealt with both comprehensively and sensitively. I particularly found useful the 'frequently asked questions' in each chapter, handled from a patient perspective and very relevant to new entrants into the speciality.

Topical areas within GUM were well addressed, including the use of chaperones, sexual health and care of under-16s, and patient confidentiality. Up-to-date topics include nucleic acid testing for chlamydia and gonorrhoea, as well as the management of lymphogranuloma venereum.

HIV medicine is a rapidly expanding and highly complex field, which was again well discussed. In relation to sexual health, there are specific chapters on HIV infection in women, contraceptive needs in HIV-positive women, and HIV in pregnancy. HIV management was covered in a system-wide fashion, in addition to important areas including pre- and post-test discussion, positive health care workers, and disclosure of status.

In summary, I found the handbook to be comprehensive, current and a useful reference source for both the DFFP/STIF and DipGUM. In addition, it is evidence-based and well resourced. Any health care professional working in sexual health or related specialities will find this an excellent guide.

Reviewed by **Gerry Gorman**, MB ChB, DipGUM, Staff Grade in Genitourinary, Family Planning and HIV Medicine, Glasgow, UK