Williams[1] has already eloquently answered the question as to whether LBC offers any real advantage over the conventional smear technique. We agree that LBC is a very welcome technological tool in the screening programme and would encourage ongoing endeavours to explore how LBC can bring further benefits to women's health.

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Implanon® insertion

I was interested to read the articles in the July 2006 issue of the Journal regarding problems related to the Implanon® device.[1–4]

I recently inserted an Implanon device into the left arm of a 23-year-old, right-handed patient. The procedure went smoothly. Eleven days after the insertion the patient presented with a 3-day history of a red rash around the site of the implant. On examination she had a lymphangitis-type reaction extending proximally and distally from the site of the implant. She was otherwise well with no systemic symptoms. The patient was commenced on oral flucloxacillin.

Three days later the patient was reviewed. The erythema had resolved. A sclerotic vessel was palpable extending from just deep to the implant to the mid-forearm. It was not tender. The patient experienced some discomfort on full extension of the arm but as she was otherwise well had opted to leave the implant *in situ*. A diagnosis of thrombophlebitis was made.

I can find no mention of this complication in the product or FFPRHC literature. I wonder if others have also seen similar cases?

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Full-term pregnancy with Implanon® *in situ*

I write in regard to the letter on full-term pregnancy with Implanon® *in situ* by Drs Cooling and Pauli that appeared in the July 2006 issue of the journal.[1]

I had a similar experience when I fitted an Implanon in a patient who, in retrospect, was probably about 4 months pregnant. She gave a history of regular periods and was bleeding when I fitted it. She had not had unprotected sexual intercourse at all according to the history.

The patient then had amenorrhoea for several months and presented to her general practitioner with abdominal swelling and weight gain. She was obviously in advanced pregnancy (perhaps not the world's brightest!).

She was 36 weeks pregnant and the hospital contacted me to see if the Implanon should be removed. I could not see any reason for doing so at such a late stage. The patient delivered without problem and chose not to breastfeed. She at least now has effective contraception for a few years!

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Reference
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Full-term pregnancy with Implanon® *in situ*

I read with interest the letter in the July 2006 issue of the Journal regarding a successful full-term pregnancy with Implanon® *in situ*.[1] I too have a patient who presented in similar circumstances and is continuing her pregnancy with the Implanon *in situ* as she would wish to use this method of contraception following her confinement.

After discussion with the patient and colleagues, it seemed that to leave the Implanon in place was an option. Time will reveal the outcome in due course.

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1 Cooling H, Pauli H. Full-term pregnancy with Implanon® *in situ* (Letter). *J Fam Plann Reprod Health Care* 2006; **32**: 204.

Full-term pregnancy with Implanon® *in situ*

The case of the full-term pregnancy with Implanon® *in situ* reported by Drs Cooling and Pauli in a recent issue of this Journal[1] raises several interesting issues.

First, *influence of pregnancy on Implanon*. As stated by the authors, the rate of release of the progestogen from the implant is likely to be unaltered in pregnancy. Also, the effects of the progestogen (both in terms of intended action and side effects) are likely to be overwhelmed by the massive increase in the placental production of progestogens.

Second, *influence of Implanon on pregnancy*. The authors correctly state that "progestogens in pregnancy have not been linked with fetal abnormality". This applies only to low-dose progestogen. High doses (>10 mg per day of norethisterone or equivalent) has been associated with masculinisation of the female fetus and hypospadias of the male fetus.[2] It is accepted that the dose of progestogen released by Implanon is low at 40 μg per day.[3]

Third, *timing of Implanon insertion*. The case in question is unique in that the Implanon was inserted after the critical period of organogenesis[4] (i.e. 10–12 weeks' gestation) when the susceptibility to teratogenic insults starts to decline. This is also the period when the luteo-placental shift becomes complete,[5] so that the placenta is now capable of detoxification. Thus, in the case described, the Implanon was effectively rendered inert, and its safety in this case cannot be extrapolated to exposure in early pregnancy. Pregnancy would continue to remain an absolute contraindication to Implanon insertion.

Fourth, *status quo*. The option of leaving the Implanon *in situ* has hardly any benefits apart from sparing the patient the minor inconvenience of removal and possible reinsertion, and negligible cost savings. Furthermore, the reason for the patient's satisfaction with Implanon needs to be explored. For example, the amenorrhoeic state may be incident on the pregnancy and not the Implanon. Hence, the patient's current experience with Implanon may not be predictive of her future response to the device.

Fifth, *primum non nocere*. It would seem biologically plausible that although low-dose progestogens have not proved to be teratogenic, zero exposure to exogenous progestogens would be the safest approach. Thus, the option of removing the Implanon would eliminate the potential for adverse effects.

Recommendation. The absence of a clear benefit coupled with a potential for harm would encourage me to advise the woman to have the Implanon removed. However, if after a full explanation of the implications she decides otherwise, I would accept her choice and support her through the pregnancy.

Postscript. A very dilute late afternoon urine sample could possibly explain the negative pregnancy test on the day of Implanon fitting. The initial pregnancy test could have been negative simply because it was too early: less than 3 weeks since unprotected sexual intercourse.[6] The interval between the two pregnancy tests has not been mentioned. If it is assumed that this is the standard practice of two negative pregnancy tests 3 weeks apart before initiation of any method of contraception, the patient is likely to have become pregnant about 8 weeks prior to Implanon fit.

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Reply

Dr Arunakumari identifies several important points. The negative urine pregnancy tests remain puzzling since the ultrasound scan performed at 27 ± 2 weeks would suggest the Implanon® was inserted when the patient was about 8 weeks pregnant (i.e. 6 weeks after conception). This means, however, that organogenesis would not have been complete by the time of insertion.

Dr Arunakumari is, of course, correct that pregnancy is a contraindication to use of Implanon. However, the issue in this case, as in Dr Melrose's case, is that removal and postnatal re-insertion of Implanon at this late stage in pregnancy subjects the patient to two extra

procedures, which are obviated by continuing with the implant already *in situ*.

The advice from Implanon's manufacturer, Organon, to remove the implant if a patient is found to be pregnant with Implanon *in situ* is normally correct, especially when pregnancy is diagnosed early. It is important that the outcome of individual cases such as these be noted so that in the unlikely event of adverse effects these may be identified in the future.

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Pelvic actinomycosis

We were intrigued to see the interesting case report from Drs Saha and Clausen in the July issue of the Journal[1] but have some thoughts concerning the aetiopathogenesis of the complex inflammatory mass described. The authors give a comprehensive discussion on the inflammatory complications of tubal occlusion but rightly state that they are rare. In our experience, pelvic actinomycosis is increasingly recognised in clinical practice, particularly if certain clinical features are manifest.[2]

These, often distinguishing, features include: (1) longstanding, mild-to-moderate lower abdominal pain, (2) fever, (3) complex pelvic masses with uterine tenderness (often indistinguishable by imaging from neoplastic lesions, (4) anaemia and leucocytosis in the peripheral blood,[3] (5) low back pain and (6) obliteration of characteristic surgical tissue planes normally identifiable at laparotomy. Although not mentioned by Saha and Clausen, like Fiorino we found weight loss and vomiting in one and two of our three cases, respectively.

Fiorino discusses the problematic nature of histopathological diagnosis in this condition.[3] In one of our small series, histology demonstrated fibrosis and inflamed adipose tissue only, as in the case described by Saha and Clausen. Particular care needs to be taken in interpreting the results of microbial culture: *Actinomyces* spp. are not always readily isolated, and secondary, opportunistic invaders may be present as 'passengers'.

Antibiotic therapy with penicillin is an important adjunct to surgery in these cases and we would urge that the diagnosis of actinomycosis is entertained in any woman with a similar presentation.

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Reply

We thank Drs Baird and Talbot for their response to our case report.[1] We agree that *Actinomyces* is an important organism involved in inflammatory masses in the pelvis. In our literature search we did not come across any case of pelvic actinomycosis associated with tubal clip sterilisation. In the case of the woman described in the case report, exploratory surgery took precedence over testing hypotheses in differential diagnosis.

Actinomycosis of the pelvis most commonly occurs by the ascending route from the uterus in association with intrauterine contraceptive devices (IUDs) or vaginal pessary. In such cases, an IUD has been in place for an average of 8 years.[2] Pelvic actinomycosis may rarely develop from extension of indolent ileocecal intestinal infection, abdominal surgery or from a perforated viscus.

It has been rightly pointed out that actinomycosis is difficult to diagnose on the basis of the typical clinical features. Had our patient been an IUD user or had any of the other predispositions mentioned above then we would have alerted the microbiologist so that an *Actinomyces* culture of the clinical specimen could be specifically undertaken.

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News Roundup

BASHH, SSHA and NCSP joint position statement

The British Association of Sexual Health and HIV (BASHH), the Society of Sexual Health Advisers (SSHA) and the National Chlamydia Screening Programme (NCSP) have published a joint position statement on information sharing that states: "Information that allows individuals to be managed effectively for genital chlamydial infections may be exchanged between health care teams* working in GU Medicine and chlamydia screening programmes operating within the NCSP. Information may include confirmation of tests taken, results, treatment given and follow-up arrangements for a named individual." [*Clinical staff and administrative staff working under their direction working in GUM, the chlamydia screening office or other clinical screening venues operating within the NCSP.]

Information will be exchanged verbally where possible. Staff identities will be verified before information is exchanged. Information exchanged will be documented in the relevant patient record. The statement does not cover communication with non-clinical screening sites.

Source: BASHH/SSHA/NCSP

Reported by **Anne Swarewski**, PhD, FFFP
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Are you breaking copyright?

The Director of the National Knowledge Service has cancelled the National Health Service (NHS) central licence with the Copyright Licensing Agency. This applies only to England as Scotland and Wales recognise the importance of a central licence and are continuing to fund this.

Why should you worry? You have probably been copying materials without thinking of the implications. The copyright law:

- Gives the creators of literary works the right to control the ways in which the material may be used.
- The rights cover copying, adapting, issuing, renting or lending copies to the public.
- The writer has the right to be identified as the author and can object to distortions of his/her work.
- International conventions give protection in most countries subject to national laws.

For the last 5 years, the whole of the NHS in England has been authorised to make copies under a centrally negotiated licence. Photocopying is an essential resource for NHS professionals for training and in providing information to patients and carers. If you incorporate other people's material in course handouts, leaflets or books for which a fee is charged, this may be regarded as copying for commercial purposes. Without this central licence you are responsible for paying copyright fees as an individual or Trust. If you do not do so, you may be breaking the law and could be sued.

Morally, it is quite wrong that authors should lose the protection of copyright for their intellectual property, as well as affecting their income. Writing books, articles, training manuals, and so on, for use by NHS professionals is very poorly remunerated (if you work out the hourly rate, it is peanuts) and this will further reduce any fees.

This action, by removing the centrally negotiated copyright licence, puts NHS staff at risk of regularly breaching copyright.

Source: http://www.cla.co.uk/copyright/copyrightlaw.html

Reported by **Gill Wakley**, MD, FFFP
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Vatican viewpoint

The Vatican has made one of its strongest ever condemnations of contraception and abortion. On 6 June 2006, The Pontifical Council for the Family published a 60-page catalogue of modern sins against the family and responsible sexuality. The document underlined the Catholic Church's teachings in the famous encyclical *Humanae Vitae* ('Human Life'), which said that only natural contraception was permitted between married couples. It also condemned *in vitro* fertilisation, artificial insemination and the use of embryos. The document was handed to journalists without any previous press release. Subsequently it has not been released on any of the Vatican's web pages, including the Council's, and has not been printed or even referred to in the Vatican newspaper.

Source: http://news.scotsman.com/international.cfm?id=837342006

STI 2005 figures

Commenting on the sexually transmitted infection figures for 2005 published on 6 July 2006 by the Health Protection Agency, Jan Barlow, Chief Executive of Brook, the sexual health charity for young people, said: "These figures illustrate how desperately investment in sexual health services is needed. It is therefore extremely worrying that in some areas facing financial pressures money earmarked for sexual health services has apparently been diverted to help balance the books. This cannot be allowed to continue at a time when waiting times for sexual health treatment remain far longer than the 48-hour target set by the Government".

Source: www.brook.org.uk

Reported by **Henrietta Hughes**, MRCGP, DFFP
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