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.

Hilary Cooling, FFFP
Associate Specialist, Contraceptive and Sexual Health Service, BANES PCT and United Bristol Healthcare NHS Trust, Central Health Clinic, Tower Hill, Bristol BS2 0JD, UK. E-mail: hilary.cooling@ubht.nhs.uk

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.

Aisling S Baird, MRCOG, MFFP
Specialist Registrar in Obstetrics and Gynaecology, Royal Hallamshire Hospital, Sheffield S10 2SF, UK. E-mail: aislingbaird@email.com

Martin Talbot, MA Ed, FRCP
Consultant Genitourinary Physician and Honorary Senior Clinical Lecturer, Royal Hallamshire Hospital, Sheffield S10 2SF, UK

References
1 Saha A, Clausen MG. Complex inflammatory abdominal mass: a late complication of tubal clip sterilisation? *J Fam Plann Reprod Health Care* 2006; **32**: 186–187.
2 Baird AS. Pelvic actinomycosis: still a cause for concern. *J Fam Plann Reprod Health Care* 2005; **31**: 73–74.
3 Fiorino AS. Intrauterine contraceptive device-associated actinomycotic abscess and *Actinomyces* detection and cervical smear. *Obstet Gynecol* 1996; **87**: 142–149.

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.

Arabinda Saha, MD, FRCOG
Consultant in Obstetrics and Gynaecology, Diana, Princess of Wales Hospital, Scartho Road, Grimsby, North East Lincolnshire DN33 2BA, UK. E-mail: arabindasaha@msn.com

Martin G Clausen, DFFP, MRCOG
Part-time General Practitioner, Newmarket Medical Practice, Louth LN11 9EH, UK. E-mail: mclausen@doctors.org.uk

References
1 Saha A, Clausen M. Complex inflammatory abdominal mass: a late complication of tubal clip sterilisation? *J Fam Plann Reprod Health Care* 2006; **32**: 186–187.
2 Fiorino AS. Intrauterine contraceptive device-associated actinomycotic abscess and *Actinomyces* detection on cervical smear. *Obstet Gynecol* 1996; **87**: 142–149.

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
Editor-in-Chief, London, UK

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
Writer, ex-GP and retired Professor in Primary Care Development, Abergavenny, UK

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
GP, London, UK