inflammation, a negative chlamydia screen, and no abnormalities detected at the woman's previous laparoscopy. One can only postulate that once ovulation occurred, the same mechanism that is known to predispose to ectopic pregnancy with oral progestogen-only contraception was responsible in this case also. Only one certain case of an ectopic pregnancy due to genuine failure of Implanon has been recorded in the literature, and interestingly the woman in that case had also had regular periods since implant insertion.[7]

Ectopic pregnancy is a potentially life-threatening condition, and the initial reports concerning the efficacy of Implanon could lull medical staff into a false sense of security that pregnancy – let alone an ectopic pregnancy – is impossible. This case illustrates the danger inherent in this way of thinking. It also highlights the need for further study of possible interactions between Implanon and other drugs.

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Statements on funding and competing interests

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References

1 Implanon Implant for Subdermal Use. Organon EU SmPC RA 0450 EU S7 (REF 7.0). http://hcp.implanon.com/Images/SMPCImplanonV7_tcm624-170329.pdf [Accessed 2 July 2006].
2 Croxatto HB, Makarainen L. The pharmacodynamics and efficacy of Implanon. An overview of the data. *Contraception* 1998; 58(6 Suppl.): 91S–97S.
3 Harrison-Woolrych M, Hill R. Unintended pregnancies with the etonogestrel implant (Implanon): a case series from postmarketing experience in Australia. *Contraception* 2005; 71: 306–308.
4 Bensouda-Grimaldi L, Jonville-Bera AP, Beau-Salinas F, Llabres S, Autret-Leca E; le reseau des centres regionaux de pharmacovigilance. Insertion problems, removal problems, and contraception failures with Implanon [in French]. *Gynecol Obstet Fertil* 2005; 33: 986–990.
5 Crewe HK, Lennard MS, Tucker GT, Woods FR, Haddock RE. The effect of selective serotonin re-uptake inhibitors on cytochrome P4502D6 (CYP2D6) activity in human liver microsomes. *Br J Clin Pharmacol* 1992; 34: 262–265.
6 Sivin I, Campodonico I, Kiriwat O, Holma P, Diaz S, Wan L, *et al*. The performance of levonorgestrel rod and Norplant contraceptive implants: a 5 year randomized study. *Hum Reprod* 1998; 13: 3371–3378.
7 Mansour M, Louis-Sylvestre C, Paniel BJ. Extrauterine pregnancy with etonogestrel contraceptive implant (Implanon): first case [in French]. *J Gynecol Obstet Biol Reprod (Paris)* 2005; **34**: 608–609..

BOOK REVIEWS

Emergencies in Obstetrics and Gynaecology. S Arulkumaran (ed.). Oxford, UK: Oxford University Press, 2006. ISBN: 978-0-19-856730-1. Price: £15.95. Pages: 290 (paperback)

This book is a new addition to the Oxford Handbook Series. It is edited by a senior obstetrician and lecturer, with contributions from both senior and junior gynaecologists and obstetricians. The book deals with common obstetrics and gynaecology emergencies presenting to admission units, A&E, outpatient departments and GP surgeries.

The layout is clear and simple and the use of different colours and symbols has worked well. References are provided at the end of most chapters. A great deal of the factual knowledge is given in the form of tables but addition of more flow charts would have made it more attractive, simple and easy to remember.

The book is divided into two sections covering most important topics relating to obstetrics and gynaecology. The first section deals with obstetric emergencies, covering all topics in the antenatal, intrapartum and postpartum periods. All the chapters are well written but the chapters relating to medical emergencies in pregnancy, obstetric complications, and intrapartum procedures and complications are particularly worth mentioning.

The second section of the book deals with gynaecological conditions that are seen in emergencies and clinics. Perhaps because there are fewer emergency situations in gynaecology the authors have devoted less space to this part of the book. Nevertheless, this section covers all the important topics. Chapters on common intraoperative and postoperative complications are very well written.

Overall, this is an excellent and comprehensive yet compact book, which is easy to understand and remember. With the introduction of Modernising Medical Careers, more foundation years doctors and specialty trainees are entering the training programme with comparatively less clinical experience, and hence this book will be a source of good clinical understanding and management of obstetric and gynaecology emergencies. This book could be a pocket companion for medical students, foundation training doctors, GP trainees and midwives working in labour wards and early pregnancy clinics.

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Family Planning Masterclass: Evidence-based Answers to 1000 Questions. G Penney, S Brechin, A Glasier (eds). London, UK: RCOG Press, 2006. ISBN: 1-904752-33-0. Price: £48.00 (limited special offer price for RCOG/FFPRHC members £36.00). Pages: 594 (paperback)

Those of you who access the Faculty website are probably familiar with the searchable Clinical Effectiveness Unit (CEU) database of member enquiries. For the less Internet inclined, this text is the paper version of the responses to the first 1000 members' enquiries. The aim is to provide a "first point of reference when faced with a clinical dilemma". No personal opinions or anecdotes allowed – once evidence has been appraised for any particular question, the CEU develop an evidence-based response.

Not all responses have been updated and there is some inconsistent information. For example, we are told that follicle-stimulating hormone (FSH) is inaccurate for assessing menopause status in women on combined oral contraceptives (p. 278) and can only be useful if the woman discontinues sex steroid hormones. Fortunately, the response to the subsequent question gives more practical guidance (i.e. that FSH levels greater than 25 mIU/ml on Day 6 or 7 of the pill-free week in perimenopausal women suggests that contraception is no longer necessary). Another example is the advice on when an IUD can be inserted (p. 142). I'll stick with teaching the 2004 CEU advice[1] "up to 5 days after the earliest calculated time of ovulation in a regular cycle" rather than the cited WHO advice "within the first 12 days after the start of menstrual bleeding". The former is by far the more practical guidance.

The heavy emphasis on evidence-based medicine does leave the clinician floundering at times. We're told that there is no evidence to support an increased dose of depot medroxyprogesterone acetate (DMPA) or a reduction in the injection interval for management of abnormal bleeding in DMPA users. Couldn't the CEU at least refer to published practice which has a body of support? Many of us shorten the injection interval in women who repeatedly bleed in the couple of weeks before the 12-weekly repeat is due. Maybe no clinical evidence yet exists but there is a physiological rationale.[2]

Some advice is just plain unhelpful, such as: "where a woman refused to follow evidence-based medical advice, the practitioner would be best to refer her to a colleague". Having been on the receiving end of such advice, I'm not sure where the referring line would end!

Would I buy it? Well, it's a useful book to have to hand but pragmatic guidance would be a welcome addition and would extend the practical application of the book. A word of caution to readers is not to consider the response to your question as definitive – it is worth browsing through the book to read the different responses to similar questions.

Reviewed by **Anne MacGregor**, MFFP
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References

1 Faculty of Family Planning and Reproductive Health Care Clinical Effectiveness Unit. FFPRHC Guidance (January 2004). The copper intrauterine device as long-term contraception. *J Fam Plann Reprod Health Care* 2004; **30**: 29–42.
2 Porter C, Rees MCP. Bleeding problems and progestogen-only contraception (FACT Review). *J Fam Plann Reprod Health Care* 2002; **28**: 178–181.