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 induced abortion is documented.

Information 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 Journal1 but have some thoughts concerning the aetio-pathogenesis 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 present.2

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

Florino 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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References


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, no explantation 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. 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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References


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Letter

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.