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Editors' highlights

We are looking forward to the British International Congress of Obstetrics and Gynaecology in July in London—not in the city centre but in Docklands, a historic area that has recently been transformed. When London's Royal Victoria Dock opened in 1855 it was at the forefront of technology, designed specifically for steamships, and by 1921 the ''Royal'' docks were the largest in the world. Today they form a backdrop to the City Airport and ExCeL, London's largest conference and exhibition centre, which will host the Congress and later be one of the venues for the 2012 Olympics.

This is the first British Congress with ''International'' in its title. It is of course hosted by the Royal College of Obstetricians and Gynaecologists but is also supported by EBCOG as well as by many specialist societies and overseas Colleges. Britain used to be in the paradoxical position of having closer links with distant countries than with its European neighbours. This is changing as more and more Europeans, including doctors, come to work in the British Isles and English is becoming widely spoken in Europe. In July Professor Bruhat of France will be one of the plenary speakers along with others from Australia, UK and America. We hope that the organisers' wish for a truly international meeting will be fulfilled. Details are available on www.bcog2007.co.uk.

What's new? Europe's changing demography is the subject of our first review, examining the effect of migration on perinatal autopsy rates. It is now common at hospital perinatal meetings to hear that ''permission for autopsy was refused'' and for this to be attributed to the family's religious or cultural background. Women from ethnic minorities, unfortunately, are at an increased risk of perinatal mortality and therefore have more to lose from inadequate investigation of poor pregnancy outcome. On page 3 Gordjin and colleagues from the Netherlands and Australia remind us that the autopsy is an integral part of the management of cases of perinatal death, and provide a helpful summary of attitudes to autopsy among major world religions—attitudes that are by no means as negative as some doctors assume. Even today, with modern techniques of imaging during pregnancy, the perinatal autopsy reveals unsuspected findings or provides additional information in 22–76% of cases. It has been shown that giving the public good information about its importance of can reverse the fall in autopsy rates.

Our second review examines the evidence on whether or not panty liners promote candidiasis or urinary infection. Readers will notice that some of the authors work for an international company that manufactures panty liners. It is fashionable to be hostile towards multinationals and to suspect their motives, whatever they do. The editors acknowledge that papers from commercial companies may well be scrutinised with even greater rigour than those from academic departments, but due respect should be given to companies who submit their products to scientific examination and publish the results in peer-reviewed journals. It is hardly surprising that they are willing to do this when the results are favourable but nevertheless the review by Farage and colleagues on page 8 will raise a few eyebrows as it challenges the traditional belief that tight, restrictive underwear encourages candidiasis.

Obstetrics and Maternal-Fetal Medicine: Rising caesarean section (CS) rates continue to cause debate (the UK rate is now approaching 25%) and the subject is attracting attention from researchers. No fewer than five of the papers this month are about CS and two of them focus on the rising rate. Kwee and colleagues (page 70) report national data from the Netherlands, which traditionally has a high rate of home delivery and a low rate of intervention compared with other developed countries. Nevertheless even there the CS rate rose from 8.1% to 13.6% in the decade from 1993 to 2002, and induction of labour in nulliparous women with a cephalic presentation at term is now associated with a 21% CS rate. On page 20 Carayol and colleagues from Paris look at a 30-year period, from 1972 to 2003, in France and focus on pre-labour CS among women with breech presentation at term. Those of us with long memories may still be surprised that in 1972 more than 85% of such women had a ''trial of labour''. By the mid-1990s, however, over 50% of nulliparous French women with a term breech presentation underwent pre-labour CS and by 2003 the figure was almost 80%, with multiparous women not far behind at 64.5%.

Obstetricians regret this change and the associated loss of obstetric skills but the fact is that we are more risk-averse than we used to be and most of our patients are even less willing to take risks with the baby's life and well-being. Nevertheless obstetricians are sometimes accused of acting in their own interests, particularly where private practice is concerned. On page 27, in a study of 79,531 deliveries in Taiwan, Xirasagar and Lin report that ''for profit'' hospitals were significantly more likely to perform CS on request than

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public or teaching hospitals. The overall CS rate in Taiwan is 32.5%—low compared with San Paolo, Brazil, where, according to Kilsztajn and colleagues (page 64), rates are 33% in the public sector and 80% in the private sector. Educated women appear to be keen on CS in spite of published evidence, readily available on the internet, that ''request'' CS has risks and should be avoided if possible. A further example of the risks is given on page 51 by Richter and colleagues from Berlin, who report that a previous CS is associated with a 52% increase in the risk of stillbirth in subsequent pregnancy.

Another effect of social class is seen on page 40, where Wielgos and colleagues from Poland report that better educated men are more likely to be present at delivery than men with trade education. Obstetricians are now familiar with having three patients in the delivery room—mother, baby and father (who often doubles as photographer). Father's presence sometimes adds to the mother's anxiety but is usually helpful and we assume that it improves family bonding. It would be interesting to know whether the father's presence at delivery is correlated with a lower incidence of subsequent marital breakdown.

The classical signs of fetal distress are fetal heart rate abnormality and meconium in the amniotic fluid. Our understanding of the fetal heart rate has increased with our long experience of electronic cardiotocography but there has been much less interest in the presence of meconium in the liquor. Indeed, the current vogue in some countries for leaving the fetal membranes intact for as long as possible in labour means that this important clinical sign is often masked. A further question over the utility of this method of fetal monitoring is raised by Becker and colleagues from Tübingen, Germany (page 46), who carried out a retrospective study of 1123 women with meconium-stained liquor in labour and found very little difference in fetal outcome between this group and a control group. The authors point out, however, that rates of obstetric intervention were much higher in the study group and this may well explain the good outcomes.

Reproductive Medicine and Endocrinology: With the advent of in vitro fertilisation (IVF) there has been a reduction in interest in the fallopian tubes as a cause of infertility. By-passing the tubes with IVF is costly, however, and failure is more likely than success. Tubal blockage can be diagnosed by laparoscopy, X-ray hysterosalpingography (HSG) or hysterosalpingo-contrast sonography (HyCoSy). HyCoSy generally uses a commercial contrast medium but Ahinko-Hakamaa and colleagues from Tampere, Finland, report (page 83) that a mixture of air and saline is a very cost-effective method, at least to select subjects for intrauterine insemination (IUI). These investigators carried out a retrospective study of 559 women who had tubal patency assessed by one of three methods and found that the best cumulative pregnancy rate (41% after 2.3 IUI cycles) was in the HyCoSy group, although delivery rates showed no statistically significant difference between the groups. The rate of ectopic pregnancy was no different between HyCoSy and laparoscopy. It is suggested that routine laparoscopy is no longer justified for infertile women but should be reserved for cases in which HSG or HyCoSy suggests tubal occlusion.

Gynaecology, Gynaecological Endocrinology and Urology: Tamoxifen has anti-oestrogen activity in breast tissue and is given to women who have been treated for breast cancer, but in the endometrium it has oestrogenic effects and is regarded as a carcinogen. Its beneficial effects on the breast outweigh its effects on the endometrium and attention is now focussed on how to minimise these adverse effects. This is the subject of two papers this month. On page 101 Garuti and colleagues from Lodi, Italy, report a study on 146 postmenopausal women who underwent transvaginal ultrasound examination before starting tamoxifen therapy. Thirty-one had abnormalities including polyps, hyperplasia and one adenocarcinoma. After tamoxifen was started annual ultrasound examinations were continued and no atypical lesions developed, although another 36 patients developed benign abnormalities. The authors recommend pre-treatment assessment and question the need for intensive endometrial surveillance after the start of therapy. Mathelin and colleagues from Strasbourg, France (page 126) report cytological sampling of the endometrium in 189 patients whose endometrial double layer thickness was >8 mm, out of a total of 687 tamoxifen-treated patients being followed up by annual ultrasound examinations. ''Endobrush'' sampling was successful in 150 of the 189 cases and detected four endometrial adenocarcinomas. The authors conclude that cytological sampling is reliable and well accepted by patients and should whenever possible replace hysteroscopy and curettage as the first-line test when endometrial thickening is detected.

Tension-free vaginal tape (TVT) has transformed the treatment of female stress urinary incontinence since it was introduced in 1995. Other techniques of incontinence surgery, however, turned out to be associated with persistent *de novo* symptoms of urgency and it seems that TVT is no exception. Holmgren and colleagues from Sweden (page 121) carried out a questionnaire study of 972 women who underwent the TVT procedure in the early years after its introduction. The average period of follow-up was 5.2 years. *De novo* urgency occurred in 14.5%, with an increased risk in older women and those with a history of caesarean section. These new symptoms had a severe effect on the women's quality of life and the authors express disappointment that expectations of a low rate after TVT have not so far been fulfilled.

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