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Editor's highlights

This year the European Community's ''Erasmus'' programme is 20 years old. It is named after Desiderius Erasmus, an illegitimate boy from Rotterdam who studied in Paris, Louvain, Cambridge, Venice and Basel and became Europe's leading scholar of the 16th century. Five hundred years later, European academics are much less mobile, partly because we no longer speak to one another in Latin. Nevertheless, despite language barriers, it is possible for students – even medical students – to undertake parts of their courses in different countries. The European Union of Medical Specialists recently reminded its members that restricting access to higher education by students from other member states is against European law.

Since the creation of the programme in 1987, over a million students from 31 countries have benefited from an ''Erasmus'' study period abroad. Details can be found at http://ec.europa.eu/education/index_en.html. Until 2006 it was linked with the ''Socrates'' programme which extended beyond universities to other areas of higher education. Obstetricians interested in history may know that Erasmus' mother was the daughter of a physician and Socrates' mother was a midwife. In our own specialty, one objective of the European Network of Trainees in Obstetrics and Gynaecology (ENTOG) is to facilitate the exchange of trainees and young gynaecologists/obstetricians and we hope that national societies will support this desirable aim.

What's new?

Reviews: Every medical student remembers that Botulinum toxin (BTX) is the most poisonous substance known to science. It must have taken considerable courage, in the 1980s, to start using it therapeutically but today it is widely advertised on the Internet in the form of injections to rejuvenate the skin. On page 4 Sinha and colleagues from Birmingham, UK, review the applications of intradetrusor BTX injections in urogynaecology. It is a neurotoxin which inhibits acetylcholine release at peripheral cholinergic terminals, and it fills the void between anticholinergics and surgery. The authors state that it will challenge the place of complicated surgical measures like augmented cystoplasty. The main indication is intractable detrusor overactivity but it is not yet licensed for this indication and its usage needs to be approved through a research protocol or a drugs and therapeutics committee.

Our second review, on page 12, is about the prediction of pre-eclampsia. Leeflang and colleagues from Amsterdam and Birmingham conducted a systematic review of studies assessing the accuracy of maternal plasma fibronectin as a serum marker before the 25th week of pregnancy. Out of 12 studies, only five reported enough data to calculate sensitivity and specificity. These included 573 women, of whom 109 developed pre-eclampsia. The authors distinguish between studies that measured total fibronectin and those that measured cellular fibronectin. At a sensitivity of at least 50%, specificities ranged between 72% and 96% for cellular fibronectin, and the authors recommend that further research should focus on cellular rather than total fibronectin. Although it is a promising marker, further studies are needed before it can be used clinically. This paper is a fine example of the meticulous care required to conduct a good systematic review.

Obstetrics and Maternal–Fetal Medicine: Breech presentation raises strong feelings among obstetricians. The well-known ''Term Breech Trial'' published in the Lancet in 2000 showed that caesarean section is safer than vaginal delivery for the fetus presenting by the breech at term. This conclusion was unpopular in some quarters and clinical guidelines emphasise that it cannot be applied to breech presentation before term. In Sweden, however, caesarean section is the standard policy for preterm delivery in many departments and on page 25 Herbst and Kallen from Lund present data to support this. Using the Swedish Medical Birth Registry, which contains information on 99% of deliveries in Sweden, they studied preterm breech deliveries from 1992 to 2002. After excluding pregnancy complications (other than preterm labour or preterm rupture of the membranes) there were almost 2000 babies delivered by caesarean section and 699 by vaginal delivery. Caesarean delivery was associated with a lower risk of neonatal death or low Apgar score, and a higher risk of infant respiratory distress syndrome—which was not, however, associated with mortality. The authors conclude that the lower neonatal mortality supports a policy of caesarean delivery of the preterm breech. Some will not surprised by this but others will still feel that the issue will be decided only by a properly randomised ''Preterm Breech

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Trial''. We doubt, though, whether such a trial will ever be successful completed.

As caesarean section rates rise, concerns are mounting about complications in subsequent pregnancies, the most worrying being placenta accreta. Sometimes this condition is diagnosed before caesarean section, but often the management has to be decided urgently during the operation, and the surgeon may be faced by a choice between trying to preserve the woman's fertility or carrying out hysterectomy as the only way to control bleeding. Conservative management is an option in some cases. On page 34 Bretelle and colleagues from Marseille, France, present a retrospective study over a 10-year period, from 1993 to 2002, during which 50 cases of placenta accreta were encountered in their two university hospitals (just over 1 in 1000 deliveries). There were no maternal deaths and the overall hysterectomy rate was 40%. In 26 patients the placenta was left in place until spontaneous resorption and in 80% of these patients this treatment was successful, with only 5 requiring hysterectomy. Three of the women managed conservatively went on to have a subsequent successful pregnancy.

Ideally such risks would be discussed in advance with the woman. Presenting risk is now a major part of an obstetrician's work, and more information is becoming available about how to do this in a meaningful way that will help a woman come to the right decision for her. On page 40 Hinshaw and colleagues from Sunderland, UK, describe a study comparing three methods of presenting information about the risk of Down's syndrome. They randomised 150 ''low risk'' women, booking before 19 weeks' gestation, into three groups which received graphic, written and interactive information. All three methods markedly reduced the women's anxiety, but the interactive method was significantly more effective in doing so. These results support the growing realisation that discussing possible complications, far from raising unnecessary worries, reassures women and reduces anxiety.

Reproductive Medicine and Endocrinology: When ovarian failure occurs, its symptoms can be treated (not always successfully) by hormone replacement therapy, but the loss of reproductive capacity can be helped only by donation of gametes. A small number of young women face losing their ovarian function because of chemotherapy and for them, removing and freezing some oocytes or sections of ovarian tissue offers the only prospect of having a baby of their own at some time in the future. There have been a small number of reports of orthotopic autotransplantation of ovaries in humans but most of the research on these difficult techniques is being done on animals. On page 70 Petroianu and colleagues from Minas Gerais, Brazil, report pregnancies after ovarian transplantation, without a vascular pedicle, between rabbits of different breeds. Pregnancy rates were higher when the ovaries were sliced before transplantation. The study confirms that a vascular pedicle is not necessary, at least in this species.

Implantation of the blastocyst into the endometrium is perhaps the part of the reproductive process about which we know least. Our knowledge is increasing, however, as research continues into the secretory products of the endometrium, particularly the endometrial glycoproteins. These have been given various names, having been erroneously called ''placental proteins'' when they were first isolated, and the most abundant is glycodelin (originally named ''placental protein 14''). Its production shows marked variations during the menstrual cycle, and is highest during the luteal phase. Its main role is to act as an immunosuppressant but it is also an angiogenic factor, which may explain its being found in high concentration close to uterine fibroids and in cases of gynaecological malignancy. Salim and colleagues from London (page 76) measured the concentration of glycodelin in uterine flushings from women with a history of recurrent miscarriage and with subseptate uteri, and found that in both groups the concentrations were lower than in normal women. This suggests that difficulty in conceiving with a subseptate uterus may be due to an unfavourable intrauterine environment and not only to implantation in the septum.

Gynaecology, Gynaecological Endocrinology and Urology: Domestic violence is an uncomfortable subject—something we hear about but prefer to ignore. In recent years we have become much more aware of its prevalence and it has been made a priority by the World Health Organisation. Nevertheless clinicians are still slow to appreciate how relevant it is to their day-to-day practice. Physical violence and sexual assault are not the only ways in which women are abused. Emotional abuse includes behaviour such as threats, humiliation, constant criticism and insults. Johnson and colleagues from Hull, UK, report (page 95) an anonymous questionnaire study of 925 consecutive women in a gynaecological clinic. The prevalence of emotional abuse was 24%, and it was four times less common over the age of 50. Abused women had significantly more consultations and were more likely to be referred for certain conditions—termination of pregnancy, cervical smear abnormalities, anxiety about cancer and urinary incontinence. Sometimes a good clinician can sense when there are other concerns underlying a patient's presenting symptom, but it is still perplexing to know how to deal with this problem.

Bearing this in mind, it might be thought that depression would be a common complication of urinary incontinence and would influence the effectiveness of treatment. This was not the conclusion, however, of Viktrup and Yalcin from Indianapolis, USA (page 105), who conducted a randomised, placebo-controlled trial of duloxetine in 1913 women with stress urinary incontinence. Among a group of 649 women assessed by the Beck Depression Inventory (BDI) only 3.5% had appreciable symptoms of depression at the start of the study—a surprisingly low proportion,

perhaps. Treatment reduced their BDI scores but the small sample size limited the power of this comparison. Overall, active treatment improved incontinence and quality of life scores, and women with a high body mass index had particular benefit on their quality of life. This pharmacologic treatment was not effective, however, in patients over the age of 65.

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