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Editors' highlights

September is always busy with conferences—too busy, perhaps. This month an international infertility meeting in Barcelona overlaps with the World Congress on IVF in Montreal, and the Asian and Oceanic Congress of Obstetrics and Gynaecology in Tokyo is followed immediately by the German Congress of Endometriosis in Berlin. Next month the World Congress on Ultrasound in Obstetrics and Gynaecology in Florence will overlap with the Congress of the European Society of Gynecology in Paris. Choice is enjoyable but environmentalists may worry about our specialty's carbon footprint.

Some meetings focus on specific needs. The European Society of Contraception is holding a seminar, *From Abortion to Contraception*, in Bucharest. Romania still has the highest abortion rate in Europe, at 79/1000 women—10 times the rate in Germany. Abortion was legalised in Romania in 1957, when contraception was not available, and by 1965 there were four abortions for every live birth. Abortion was banned again in 1966 and draconian pronatalist policies were introduced, but it was only after the fall of Ceausescu in 1992, when young women got access to sex education and free contraception that abortion rates began to come down. Nevertheless old habits die hard, and the average woman in Romania still has more than two abortions in her lifetime. Romania is not alone: in Russia, for example, the lifetime risk is similar. Perhaps we need even more seminars.

What's new? This month's review, by Quaas and Ginsburg from Boston, USA, (page 3) is about the prevention and treatment of uterine bleeding in haematologic malignancy. The authors conclude that GnRH agonist treatment is effective in prevention and that medical treatment is usually successful for acute bleeding, though expeditious surgery may required. This specialised problem is typical of uncommon clinical conditions that involve more than one specialty, where each may feel that the other has more knowledge and experience. Quaas and Ginsburg found that the literature consists mainly of case series and pilot studies, and they recommend more research and close co-operation between the specialties. We echo this call but we recognise that such recommendations are hard to implement. Research on uncommon conditions requires careful organisation at a regional or national level. Development of evidence-based guidelines will take time and we should not sit back and wait for them. As these authors point out, when evidence is not available, high quality empiric algorithms are needed.

Obstetrics and maternal-fetal medicine. Giving information to patients is a major part of an obstetrician's job and in a recent issue we commented on how difficult this can be. On page 9 Alouini and colleagues from Paris and Vilnius describe a study of patients' views on the information they received before undergoing prenatal diagnosis. With some procedures, such as amniocentesis, the information was generally adequate but with others a substantial minority of patients would have liked more information, including photos of the abnormalities and possible surgical repairs. Most of the women who underwent termination of pregnancy felt they received inadequate information about that procedure. We need to recognise the difficulty of giving information about subjects that we ourselves may find difficult to reflect upon or talk about.

Neonatal neurological damage is an ever-present worry for obstetricians because of its drastic effects on the child and the family and because the doctor is commonly blamed for failing to prevent it. Dupuis and colleagues from Lyon, France (page 29) conducted a retrospective study of all infants referred to a tertiary unit for suspected neurological damage during 2003. Each case was reviewed in detail by an expert committee to determine whether or not there were potentially avoidable factors. This is a time-consuming but very useful technique used in maternal and perinatal mortality surveys and it can yield important information. The French investigators confirmed neurological damage in 40 of the 75 cases referred, and found potentially avoidable factors in 29 of these 40 cases. It is important that lessons are fed back to the staff involved so that such factors can indeed be avoided in future.

Almost a quarter of a century ago, the *Lancet* published "Birth Under Water" by the French obstetrician Michel Odent. The paper was illustrated by a charming picture of a mother and baby and we suspect that the continuing popularity of water birth over the last 25 years owes as much to photography as to medical science. Obstetric resistance to water birth, however, has faded. On page 37 Zanetti-Dallenbach and colleagues from Basel, Switzerland report a large prospective study comparing women who had a water birth with those who delivered after immersion and those who had a normal vaginal delivery without immersion. They found no differences in maternal infection rates or in fetal

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outcome parameters. Water birth was associated with less use of analgesia and a shorter first and second stage of labour, but a small number of babies had conjunctivitis. The authors note that their results are consistent with those of the Cochrane review, and conclude that water birth is a valuable alternative to normal delivery but careful selection of low risk women is required.

Reproductive medicine and endocrinology. The oral contraceptive (OC) pill has remained enduringly popular among young women since its introduction more than 40 years ago, despite much publicity from time to time about its risks, both real and imaginary. Patterns of contraceptive use vary from country to country, however. Germany experienced great social change with reunification in 1991 and its effect on contraceptive use is reported by Du and colleagues from Berlin on page 57. They compared 1862 OC users and 2625 age-matched non-users from five German National Health Surveys between 1984 and 1999. Throughout that period in western Germany, OC use remained constant at just under 20% of women of reproductive age, but in eastern Germany there was a decline from 43% in 1991 to 32% in 1999. OC users were generally healthier than non-users, but it is hard to say whether this is a cause or an effect of OC use.

Debate has continued for many years over the relationship between female sex hormones and the risk of coronary artery disease. Among premenopausal women heart disease is less common than among men of the same age but after the menopause the gender difference becomes steadily less. This raised hopes that postmenopausal hormone replacement therapy would have a protective effect but this has not been confirmed by epidemiological studies. On page 67 Bertuccio and colleagues from Milan, Italy, report an analysis of three Italian case-control studies comparing 609 women admitted with acute myocardial infarction (AMI) and 1109 women admitted with other acute conditions. Irregular menstrual cycles and parity were related to the risk of AMI, especially in premenopausal women. The authors think these effects are due partly to endocrine factors and partly to confounding.

Gynaecology, gynaecological endocrinology. Sterilisation was once a highly controversial procedure but is now an option chosen by many women after their family is complete. Techniques have steadily evolved during the last 30 years and laparoscopic tubal occlusion has become the standard method in Europe. Women requesting postpartum sterilisation may be told that they have to wait until after the puerperium, but this brings the risk of non-attendance and subsequent unwanted pregnancy. Huber and colleagues from Berne, Switzerland and Varese, Italy, report on page 105 a large study of the safety of different approaches – interval laparoscopy, postpartum laparoscopy and postpartum minilaparotomy. A total of 27,653 patients were included. The authors found that major complications were commoner with minilaparotomy but laparoscopy was safe whether performed as an interval or a postpartum procedure. Those of us who instinctively feel reluctant to undertake laparoscopy in the postpartum period will have to think again.

Gynaecological urology. Urogynaecology is a relatively new subspecialty that has expanded rapidly over recent years, and the increased number of research papers now justifies a separate section in *Editors' Highlights*. As a result of this rapid growth, clinics in some centres are becoming very large and specialists are finding it hard to cope. In a publicly funded service like the UK's National Health Service, pressures are particularly high. On page 120 Jha and colleagues from Birmingham and Worcester, UK, describe an integrated care pathway developed in a district general hospital. This speeded up access to diagnosis and treatment and allowed 35% of patients to be managed by urogynaecology specialist nurses without seeing a doctor. Patient satisfaction with specialist nurse services is generally high, but when financial cuts are required these are the services that are often most vulnerable.

A reason often cited for the rise in caesarean section rates is the risk that vaginal delivery may cause damage to the pelvic floor and subsequent incontinence. Overt anal sphincter injuries are generally obvious at delivery but occult disruption of the sphincter may not be detected until much later, when the opportunity for early surgical treatment has passed. Recently interest has been growing in the use of transperineal ultrasound (TPUS) to examine the anal sphincter after delivery. TPUS is less accurate than endoanal ultrasound but is easier to use. On page 115 Maslovitz and colleagues from Tel Aviv report a study correlating clinical findings with TPUS performed on the day of delivery. Of 35 women complaining of anal incontinence on day one, 31 had sphincter damage demonstrated by TPUS. Six months later 27 of these 31 women still had symptoms but all four women who had an intact sphincter on ultrasound examination were asymptomatic. The authors suggest that TPUS could be useful as an aid in screening for anal sphincter tears.

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