



Editors' highlights

In 1826 a group of German professors with advanced ideas founded the “Common German Journal of Obstetrics” (*Gemeinsame deutsche Zeitschrift für Geburtskunde*) under the editorship of W.H. Busch of Marburg, L. Mende of Göttingen and F.A. Ritgen of Giessen. The editors wanted the content of the new journal to comprise obstetrics in the broadest sense. Similar activities also started in other European countries. At this time maternal mortality was elevated and infant mortality was incredibly high. Information and discussion about normal and pathologic situations during delivery were the first steps in improving the quality of obstetrical services. “The usual process of birth”, the first article written by Ritgen in volume 1, was followed by reports of remarkable cases and discussions about methods of caesarean section. Gynaecology was not a topic as it was conducted by surgeons under difficult conditions. Gynaecological surgery became part of our specialty at the end of the 19th century when surgery was less risky and easier to conduct thanks to the development of new anaesthetic methods. Female endocrinologic disorders aroused great interest in the middle of the 20th century.

Since then, huge steps in the development of our profession have taken place, paralleled by advances in laboratory methods, technical improvements and surgical procedures during the past 50 years. This has led to the creation of subspecialties, which are represented in our Journal's content. Our basic specialty, obstetrics and gynaecology, now comprises four subspecialties and you may have noticed that a fourth section, “*gynaecologic urology*”, has been added to our Journal. It reflects the decision of the European Board and College of Obstetrics and Gynaecology (EBCOG) to create an additional subsection, “Gynaecological urology”, taking into consideration the broad development of research in diagnostic and therapeutic procedures. It is our aim that the European Journal will provide you with the latest progress in this important field and demonstrate the expansion of the profession in research and treatment which continues to take place.

What is new? The development of meshes has widened the possibilities in urogynaecologic surgery, and the introduction of the transvaginal tape (TVT) has created a new type of surgical approach in the treatment of female incontinence. Prolapse in women is a further indication for implanting meshes to stabilize the pelvic organs. In this context the biomechanical properties of synthetic mesh

deserve special attention (see Boukerrou and colleagues from Lille, France on page 263). New operative procedures, however, bring a certain number of complications. The review from Falagas and colleagues (page 147) focuses attention on mesh-related infections after prolapse repair. In the literature the ranges of mesh-related infections and erosion were 0–8% and 0–33%, respectively. The authors discuss the effect of various factors such as the kind of biomedical material, the type of procedure, the preventive measures taken and the age of the patient. They recommend being aware of these complications and that this information should be part of informed consent.

Hormone therapy is always a difficult subject in counselling patients who have suffered from cancer of the breast. Is it justified to prescribe hormones to postmenopausal patients who had breast cancer? Franke and colleagues, from Enschede, The Netherlands, say “yes” (page 143) “but good information about the advantages and disadvantages should precede the decision”.

Obstetrics and maternal-fetal medicine: Migraine is considered to be a vasoconstriction of the cerebral vessels with various locations. Its relationship to complications during pregnancy has not been analysed until now. Banhidy and colleagues from Budapest (page 158) found that 1.9% of women had severe migraine during pregnancy and these women had a higher prevalence of preeclampsia and severe nausea and vomiting. The question remains whether an endothelial factor is responsible.

Forceps is an instrument by which power is applied to deliver the fetus but the vacuum extractor (VE) needs skilful handling to prevent it sliding off the fetal head by incorrect traction. Abenhaim and colleagues from Montreal (page 165) investigated the effect of user preference on the rate of operative vaginal deliveries and caesarean section. Physicians who preferred forceps were better in handling deliveries, with lower rates of operative delivery and caesarean section, and lower rates of episiotomy in normal deliveries. The authors conclude that “physicians' preference is an important determinant of outcomes that should be considered in studies evaluating instrumental deliveries”. Would it therefore be better to train doctors to use just one instrument? This would give better skills with the chosen instrument and avoid switching from one to the other, which adversely influences fetal outcome. But what about the results if only VE is used?

Polat and colleagues from Ankara, Turkey (page 170) used an in vitro model with umbilical arteries to investigate

the relaxation response to the new potassium channel opener, levromakalim, and compare it with two other antihypertensive drugs, nifedipine and magnesium sulphate. Responses to all three drugs were identical, in arteries from both healthy and preeclamptic women. Since the mechanisms of action of the three drugs are different, it would be interesting to learn what effect can be expected if they are given simultaneously.

Relaparotomy after caesarean section is rare and generally associated with severe complications. Lurie and colleagues from Holon, Israel (page 185) assessed the rate, indication and outcome of relaparotomy in a retrospective observational study of 3380 women who underwent a caesarean section out of 18,609 parturients. Relaparotomy took place in 18 cases (0.53%). The indication in most cases was haemorrhage (66%) followed by eventration (17%) and intra-abdominal abscess (17%). In an interesting discussion the authors make recommendations for reducing the need for relaparotomy. We suggest also that a clear protocol is recommended in such cases to be prepared for an upcoming lawsuit.

“The host response to microbial invasion in the lower female genital tract is genetically determined” is the conclusion of Genc and colleagues from Boston and New York, USA, who investigated 203 vaginal samples from women at 18–22 weeks' gestation (page 189). TNF- α concentration was elevated in TNFA-308A carriers, but only in the presence of abnormal vaginal flora. TNF- α concentration without Bacterial Vaginosis (BV) was 1.77 pg/ml; with BV it was 10.9 pg/ml. In TNF-308G homozygotes with BV, by contrast, it was low at 1.72 pg/ml. The results may shed light on susceptibility to HIV infection and to preterm labour.

Reproductive medicine and endocrinology: Anti-Müllerian hormone (AMH) is secreted by the Sertoli cells during male embryogenesis and suppresses development of the female genital tract. It is also produced by ovarian granulosa cells after puberty and according to Somunkiran and colleagues from Duzce, Turkey (page 197) it is elevated in patients with polycystic ovary (PCO) syndrome: 5.49 (SD 2.26) versus 1.93 (SD 0.51) ng/ml. The elevation is not influenced by treatment with oral contraceptives. This finding deserves further attention. A genetic influence on PCO can also be observed by comparing South Asian woman with Caucasian counterparts. Asian women with PCO exhibit a greater sensitivity to gonadotropin stimulation than Caucasian women, as found by Palep-Singh and colleagues from Leeds, UK (page 203). Would it be rational to look also at AMH concentrations?

Lowenstein and colleagues from Haifa, Israel, (page 209) have studied endothelial function in PCO, using a post-ischemia reactive hyperemia technique to investigate vascular reactivity. Endothelial dysfunction occurs preferentially in women with PCO and is not improved by metformin. Again, it

would be interesting to know whether in these women the AMH concentration is also elevated. The response of the readers to this topic would be very much appreciated.

Gynaecology and gynaecological oncology: Uterine fibroids usually shrink after the menopause due to a decrease in circulating oestrogen. To facilitate the surgical removal of huge leiomyomas before the menopause, preoperative treatment with GNRH analogues has been recommended in recent years but the doses of the drug have not been clearly described. Engel and colleagues from Würzburg and Lübeck, Germany, Clamart, France and Prague, Czech Republic, investigated in a multicenter study the optimal doses that should be used (page 226). Cetorelix acetate was given in different doses and the size of the myomas was measured by MRI at zero and at day 29 and compared to a group without treatment. The highest response rate (reduction of uterine volume by $15.4 \pm 34.6\%$) was achieved with 4×10 mg cetorelix acetate. This dosage is recommended as a flexible treatment protocol without any major side effects.

Pipelle Mark II sampling has been designed for combined cytological and histological testing of the endometrium. Polena and colleagues from Paris (page 234) tested the feasibility of this method in 97 women with abnormal uterine bleeding or intrauterine lesions on ultrasound examination. Samples obtained were insufficient for cytological and histological diagnosis in 14 and 11% of patients, respectively, but the results were better in the 57 women who were postmenopausal. The authors comment that sampling does not replace ultrasonography and diagnostic hysteroscopy, which should be used when abnormal bleeding persists.

Gynaecological urology: Involuntary loss of urine under stress conditions such as coughing, laughing and exercise is a burden carried by many women aged 40 and above. It is related to the number of previous deliveries but also has hereditary causes and may be related to oestrogen receptor concentration in the genital tract. Xie and colleagues from Hangzhou, China, investigated (page 255) the concentrations of estrogen receptor- α and β (ER- α and ER- β) in the anterior vaginal wall of women with stress urinary incontinence (SUI). They found that serum estradiol was lower in women with SUI than in controls but only before the menopause: after the menopause there was no difference. ER- α in vaginal tissue was lower in women with SUI than in controls but, again, only in the premenopausal group. ER- β in fibrocytes, however, was lower in women with SUI than in controls in both groups—pre- and postmenopausal. These interesting findings focus attention on the role of circulating oestrogen before the menopause and the role of ER- β after the menopause.

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