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Editors' highlights

Europe's boundaries are hard to define. Greenland, to the west, has left the European Union but is still part of the kingdom of Denmark. On the southern Mediterranean coast, African and European cultures mingle. Eastwards, Turkey is working towards membership of the European Union. To the north-east, Russia has been a European power since the time of Peter the Great and today the World Health Organisation's Europe office is responsible for all the former Soviet republics up to the Chinese border. In some of these republics women's health is poor and there may be benefit from collaboration with western Europe. The Royal College of Obstetricians and Gynaecologists (RCOG) in London has an International Office which is building relationships with eastern Europe under its ''Eurovision'' initiative. A workshop is to be held about this in December 2007. Some RCOG guidelines are being translated into Russian and information about this is available from bpatel@rcog.org.uk. We hope that more of the UK's evidence-based guidelines will be translated into other languages, particularly Russian.

What is new? Borderline ovarian tumours account for 10–15% of ovarian cancers. The prognosis is generally good (with 5-year survival as high as 99.5% for some types) and 27% of patients are less than 40 years of age. Therefore although standard treatment is the same as for invasive cancer, some women may wish to preserve their fertility. On page 3 Swanton and colleagues from Oxford, England, review 19 studies with a total of 2479 patients of whom 923 had conservative surgery. Pregnancy outcome data were available in nine studies. The authors found a 48% pregnancy rate and a 16% recurrence rate, with only five disease-related deaths. These data will be valuable in counselling women with this condition.

The most frustrating aspect of in vitro fertilisation (IVF) programmes is the low implantation rate and our second review (page 8) focuses on the link between implantation and endometrial blood flow. Ng and colleagues from Hong Kong review studies which have attempted to relate IVF outcome to three-dimensional power Doppler ultrasound measurement of endometrial and subendometrial blood flow. Changes can be detected between the late follicular and early luteal stages of the cycle and the authors conclude that these require more investigation.

Obstetrics and maternal–fetal medicine: Although breech presentation now usually leads to caesarean section, obstetricians still need to know how to conduct vaginal breech delivery (VBD), to allow maternal choice or to deal with an emergency. Training is becoming difficult, however, as VBD becomes rarer. On page 17 Carcopino and colleagues from Marseilles, France, describe a survey of 817 French trainees who returned 140 usable questionnaires. Overall, 35% of trainees had received no training in VBD. Of senior trainees, 33% had performed fewer than four such deliveries. The authors predict a further rise in caesarean section rates and recommend a rethink of clinical skills training.

Obstetricians and lay people agree that caesarean section rates must fall but this seems hard to achieve in reality. Benedetto and colleagues from Torino, Italy, shed some light on this paradox on page 35. They studied 1407 healthy women with normal term singleton pregnancies, divided into four groups: spontaneous delivery, instrumental delivery, planned caesarean and caesarean section in labour. Maternal and neonatal complications were mainly associated with instrumental deliveries, even when compared with caesarean section in labour. Complication rates were similar with spontaneous deliveries and caesarean sections. This supports the trend towards caesarean section and away from instrumental delivery, and again raises concern about training young obstetricians in instrumental deliveries for emergencies.

One third of preterm deliveries follow preterm premature rupture of the membranes (PPROM). The timing of intervention is difficult as the obstetrician has to balance the risks of prematurity against those of infection. On page 21 Pasquier and colleagues from France and Canada describe a study of 471 women with PPROM between 24 and 34 weeks' gestation. They found that a short latency period (<48 h) was associated with a higher infant mortality rate before 30 weeks but a lower rate after 30 weeks. Expectant management is the norm for PPROM, as the authors point out. These results suggest that a major reappraisal may be needed.

Electronic fetal monitoring (EFM) saves babies' lives but also leads to unnecessary caesarean sections. When EFM shows abnormalities in labour, fetal blood sampling should be the next step but is not always possible. The ''STAN'' system therefore added electrocardiography (ECG) to EFM in an effort to improve its specificity. Initial studies showed reduced intervention rates as well as less fetal acidosis but this was not confirmed by a more recent study. On page 28

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Kwee and colleagues from Utrecht, The Netherlands, report a retrospective analysis of 563 combined fetal heart rate and ECG recordings. They found that in the first stage of labour ST changes in the ECG were as frequent in normal as in abnormal traces. They comment that this may lead to confusion for inexperienced doctors and midwives, and recommend regular training on STAN interpretation. This will be supported by all who have used STAN in clinical practice.

French women undergo routine monthly serum screening for toxoplasmosis in early pregnancy. If seroconversion occurs, the fetus is checked by ultrasound and if abnormalities are found the pregnancy is usually terminated. When scans show no abnormality the question is: what is the risk of allowing the pregnancy to continue? Studies have shown that continuing is safe in the second and third trimesters, and now on page 53 the same investigators address the first trimester. Berrebi and colleagues in 12 centres studied 36 children infected in the first trimester whose scans remained normal throughout pregnancy. Subclinical toxoplasmosis was present in 78%, and 19% had chorioretinitis but without major vision loss. One child developed severe congenital toxoplasmosis. The authors conclude that termination of pregnancy is not justified but they stress that all the women received prompt treatment and only those whose scans remained entirely normal were included in the study.

Reproductive medicine and endocrinology: Until 1978 contraceptive methods were illegal in Spain but since then their use has steadily increased. A national survey is conducted every two years and on page 73 Lete and colleagues report a steady increase in use of contraception by Spanish women aged 15–49, from 55.6% in 1997 to 71.2% in 2003. Almost 50% of respondents said their main source of information about contraception was healthcare professionals, which is perhaps surprising as the most widely used method was the condom. We look forward to the authors' next paper, on contraceptive use in different age groups.

In Finland more than half of undergraduate university students are over 25 years old and 80% are sexually active. Virtala and colleagues (page 104) report a questionnaire study of 5030 male and female students, with a 62.7% response rate. About half the female students were using hormonal contraception and one-third used a condom. Almost half the men used a condom. Simultaneous use of two methods was rare and condom failure was common. These results are not reassuring from the point of view of preventing sexually transmitted disease.

For men infected with HIV, condom use is essential to protect their partner but if they are in a stable heterosexual relationship they may want to conceive. Sperm washing followed by intrauterine insemination can achieve this safely. On page 76 Bujan and colleagues from Toulouse, France, report a retrospective study of 84 serodiscordant couples, compared with 90 couples undergoing IUI with donor sperm. Pregnancy and take-home baby rates were higher with washed sperm but differences were not statistically significant. No female contamination with HIV-1 occurred.

Gynaecology and gynaecological oncology: Peristalsis occurs in the non-pregnant uterus throughout the menstrual cycle and can be detected by ultrasound. In the early follicular phase the direction is from fundus to cervix but in the periovulatory phase it goes the opposite way and increases in intensity. Later in the cycle the uterus becomes quiescent. On page 111 Orisaka and colleagues from Fukui, Japan, report a pilot study using cine magnetic resonance imaging to evaluate uterine peristalsis. They suggest that abnormal peristalsis may be the reason for the heavy menstrual bleeding and infertility associated with fibroids.

During sexual arousal most vaginal lubrication is due to transudate. Bartholin's glands emit their secretion in the late excitement and early plateau stages but its function remains unclear. Chretien and Berthou from Paris (page 116) studied Bartholin gland secretions in normal subjects and demonstrated for the first time the "ferning" which was first described in ovulatory cervical mucus. Bartholin's secretion, however, does not change during the menstrual cycle. The authors plan further studies on these glands, which may yet prove to have functions other than making work for emergency gynaecologists.

Gynaecological urology: As mentioned above, the different languages used across Europe are a challenge to many people, including those undertaking questionnaire studies. Questionnaires which give accurate and useful answers are not easy to design and need to be tested and validated. Translation may introduce errors and use in a new cultural context may introduce inaccuracies. On page 132 Cam and colleagues from Istanbul report that the prolapse-quality of life questionnaire, originally written in English, has been translated into Turkish and is a reliable and valid instrument which can be easily self-completed by Turkish women.

J. Drife
W. Kuenzel

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