European Journal of Obstetrics & Gynecology and Reproductive Biology 142 (2009) 1–2

Contents lists available at ScienceDirect

European Journal of Obstetrics & Gynecology and Reproductive Biology

journal homepage: www.elsevier.com/locate/ejogrb

Editors' highlights

At the start of a new year we all like to look forward and already some forthcoming events in our specialty are creating a sense of anticipation. The nineteenth FIGO World Congress of Gynecology and Obstetrics will be held in Cape Town in October (www.figo.org/meetings_congress_world.asp). This city, at the meeting-point of two oceans and overlooked by its famous mountain, is a beautiful setting, and South Africa, ever since its first democratic elections in 1994, has been an inspiring country for the rest of the world. Last year its national team won the Rugby World Cup and in the world of health care *Saving Mothers*, South Africa's national reports on confidential enquiries into maternal mortality, are widely recognised an example to other countries (www.hst.org.za/indicators/ReproHealth/saving_mothers_2003.pdf).

FIGO has steadily grown in stature since being founded 54 years ago and now for the first time has a woman president, Dr Dorothy Shaw. In her invitation to the World Congress she points out that 2009 is the 30th anniversary of the Convention for the Elimination of Discrimination against Women, which was adopted by the United Nations General Assembly in 1979 and is often described as an international bill of rights for women (www.un.org/womenwatch/daw/cedaw/cedaw.htm). We are painfully aware that all countries still fall short of complete elimination of this form of discrimination and we know how great this shortfall is in many places, particularly in Africa. Nevertheless progress is being made and one of the optimistic signs for 2009 is increasing political awareness of the need to improve women's health. Dr Shaw is from Canada, a country which is leading the way in global co-operation in women's healthcare, and the local and international committees organising this year's Congress are packed with talent. We look forward to a landmark meeting.

What's new?

The problem of preterm birth continues to tantalise. Despite our increasing knowledge of the biochemistry of uterine contraction and cervical maturation (see for example, the paper by Choi and colleagues on page 43) we still do not have reliable interventions to prevent or treat preterm labour. Immaturity remains the leading cause of neonatal death in many countries including the UK, where it caused over 1000 neonatal deaths in 2006. The costs involved in successful or unsuccessful treatment of these babies are described as "staggering" by Smith and colleagues from Dublin in this month's review (page 3). They comment that the medical literature now contains hundreds of studies of interventions for prevention and treatment of preterm birth—far too many for clinicians to appraise and use in decision-making. Most of us therefore rely on systematic reviews but the Dublin team point out that these are of varying quality and that there is now a plethora of such reviews, with more than one on some important topics. They have therefore conducted a systematic review of systematic reviews, looking at five interventions—antibiotics, cervical cerclage, bed rest, progesterone and tocolytic therapy. They identified 37 reviews and included 22 in their systematic review of reviews. This represents an enormous amount of research effort and it seems presumptuous to try to sum it all up in a sentence, but we cannot resist the temptation. Antibiotics may delay but not prevent preterm birth and the use of progesterone appears promising.

Obstetrics and maternal-fetal medicine

Rising rates of caesarean section (CS) are a concern in developed countries. Among the adverse effects of CS is increased blood loss compared with vaginal delivery but management of the third stage at CS has received little scientific attention. As Murphy and colleagues from Scotland and Ireland point out on page 30, it has been assumed that the benefits of active management at vaginal delivery also apply to abdominal delivery. Murphy and colleagues randomised 115 women undergoing elective CS: one group received a bolus of 5IU oxytocin followed by an infusion of 30IU oxytocin and the other group received the same bolus injection followed by a placebo infusion. Estimated blood loss was lower with the oxytocin infusion and fewer women had a major haemorrhage. This was a pilot study for a large multicentre trial which will require 1500 women in each arm to demonstrate a 3% reduction in major haemorrhage with >80% power. Painstaking work like this provides the basis for evidence-based obstetrics and may in time make elective caesarean section even safer than it is already.

One of the reasons for the rise in elective CS rates is better prenatal diagnosis, which alerts obstetricians to the at-risk fetus. On page 18 Radboisson and colleagues from Lyon, France, report a series of 121 cases of transposition of the great arteries over a 6-year period. In 48 cases the diagnosis was made before delivery and in 73 it was made postnatally. Rates of CS and induced labour were much higher in the prenatal group but the authors report that this did not have any impact on the newborn except for earlier admission to the intensive care unit and easier umbilical atrial septostomy. They comment that the higher CS rate may have adverse effects on mothers' long-term health and this issue needs further investigation.

Fetal growth restriction is another frustrating problem for obstetricians. We do our best to diagnose the condition but we are not good at screening for it in "low-risk" pregnancies. In the most recent study of perinatal mortality in the UK (www.cemach.

0301-2115/$ – see front matter © 2008 Published by Elsevier Ireland Ltd.
doi:10.1016/j.ejogrb.2008.11.001

org.uk), over 50% of stillbirths were "unexplained" and of these, 26% showed severe growth restriction (<3rd centile). Ideally, growth restriction would be treated in utero but as yet we do not know enough about it to do this. On page 38 Struwe and colleagues from Erlangen-Nuremberg, Germany, report a study of adipokines (leptin, resistin, adiponectin and ghrelin) in placentas from normally grown and small-for-gestational-age (SGA) neonates. Leptin gene expression was higher in the SGA group but the expression of the other adipokines was unchanged, casting doubt on their role in fetal programming.

Reproductive medicine and endocrinology

We are learning a great deal about nitric oxide (NO) these days and it is no surprise to find that it has a variety of roles in reproductive medicine. On page 48 Gallinelli and colleagues from Reggio Emilia, Italy, give a list of roles which include folliculogenesis, oocyte maturation, fertilization, implantation and embryo cleavage. These researchers studied the possible role of NO in the early phases of embryo cleavage during assisted reproduction. Using fresh oocytes from 123 women and 56 from oocyte thawing cycles, they measured NO oxidation products in the IVF or ICSI culture media and related these to embryo quality. No correlation with embryo quality was observed but embryos from fresh oocytes produced more NO than those derived from thawed oocytes. They conclude that although it is not a metabolic cleavage marker, NO may be useful in investigating metabolism in frozen/thawed oocytes.

Gynaecology and gynaecological oncology

Ovarian tumours diagnosed in childhood are rare and correct management is crucial for the patient's reproductive future. The commonest type of neoplasm is a teratoma but up to 30% are epithelial tumours, most of which are benign serous or mucinous cystadenomas. On page 64 Massicot and colleagues from France and Switzerland report a retrospective study of 42 cystadenomas in children less than 16 years old treated between 1985 and 2003. The mean age at first surgery was 11.5 years. Cystadenomas can appear as early as 5 years of age but papillary proliferation may require the hormonal stimulus that begins at puberty. The authors strongly advocate complete removal of the tumour with preservation of normal ovarian tissue.

Acupuncture is increasingly widely used for gynaecological conditions in Western countries. In Chinese medicine it is perceived as affecting the flow of life force along meridians but Western medicine has focussed on neurotransmitters in the brain, with studies suggesting that acupuncture may influence the synthesis of endorphins. On page 68 Stähler van Amerongen and colleagues from Bern, Switzerland, report a randomised comparison of metal needle and laserneedle acupuncture in 60 patients attending the Department of Gynecology in Bern in 2001–2. The range of indications for treatment was broad and included premenstrual pain, smoking withdrawal in pregnancy and induction of labour. Laserneedle treatment was less painful and more likely to produce a feeling of warmth all over the body. Tiredness during treatment was similar in both groups and improvement in symptoms after treatment was also similar. The authors describe laserneedle acupuncture as painless and easy to apply. We would like to see placebo-controlled studies, which are feasible but still relatively infrequent in this field.

Gynaecological urology

Gynaecological practice encompasses a range of skills from psychosexual counselling to surgery but as Gauruder-Burmester and colleagues from Berlin point out on page 76, there is a persisting and highly restrictive division between urologists and sexual therapists. It is important to improve connections between these subspecialties. More and more surgical options are becoming available for the treatment of vaginal prolapse and at the same time there is an increasing recognition that sexuality does not end at the menopause. Nevertheless only a few studies have investigated sexual function in women who have had prolapse repaired with polypropylene mesh. Using a validated questionnaire, the research team from the German Pelvic Floor Center asked 120 women about their sex life before mesh insertion and 1 year afterwards. Before surgery, fifteen of the women reported dyspareunia which was related to the prolapse but at 1-year follow-up no woman complained of dyspareunia. However, one third of the women had more deeply rooted sexual problems based on partnership problems and unrelated to surgery. One of the most difficult challenges in our specialty is helping patients who are seeking a surgical cure for social or relationship problems and wise judgement may be needed to decide when operation is required. It is very reassuring, however, to learn that mesh repair does not interfere with a healthy sex life.

J. Drife
W. Künzel