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# Editors' highlights

Six months ago, in the Editors' Highlights of our October 2008 issue, we described the "Maternal and neonatal health – obstetric fistula" project in Northern Nigeria. It is supported by The Rotary Foundation, the Aventis Foundation, the Bundesministerium für Zusammenarbeit und Entwicklung and Rotary Clubs from Nigeria, Germany and Austria. We pointed out that this project, which uses a benchmarking model in 10 hospitals in Kaduna and Kano, is designed to reduce the high maternal and fetal mortality in that area. Data from the 10 hospitals are now available for the first and second halves of the year 2008, regarding maternal mortality rates (MMR), fetal mortality rates (FMR), rates of preeclampsia and postpartum haemorrhage, numbers of caesarean sections and other indicators of maternal health. Analysis of these data provides some interesting insights into the relationship between hospital structure and outcome quality. There is a high variability of MMR and FMR among the hospitals. Those with high delivery rates have lower MMRs (although still about 500/100 000 deliveries) compared with hospitals with small numbers of deliveries, which have MMRs of up to 6%. During 2008, comparing January to June with July to December, the MMR fell in the second half-year period in three hospitals, remained constant at high or low levels in four, and rose in three hospitals – discrepancies which need further investigation.

The data were intensively discussed by representatives of the participating hospitals at the second half-year meeting of "Quality Assurance in Obstetrics" on 21st February 2009 at the Amino Kano Teaching Hospital. We are convinced that these evaluations will continue the process of competition and stimulate fruitful discussions leading to an improvement of MMR and FMR in these and other hospitals. If this model is successful we hope it will spread to other hospitals in the region, headed and guided by a regional office on quality assurance in obstetrics in Nigeria.

## What's new?

Cancer staging is essential for planning treatment, formulating prognosis and evaluating results of therapy. Staging of cervical cancer began 80 years ago under the auspices of the League of Nations, as described recently in a paper by Odicino and colleagues (Int J Gyn Obstet 2008;101:205–10). In 1958 FIGO assumed responsibility for the gynaecological cancer staging system which has now become familiar to all gynaecologists. The traditional FIGO classification has evolved over the years in response to developments in research and practice, and on page 69 Petru and colleagues report on the most recent proposals for change. FIGO invited the Gynecologic Cancer Intergroup (GCIG), represented by colleagues from Austria, Germany, USA, United Kingdom and Belgium, to make contributions for possible changes to the current staging system, and the GCIG committee has reached a consensus on its recommendations. The proposals are as follows. For cervical cancer, stage IB1-A may include tumors up to 2 cm; for endometrial cancer peritoneal cytology should not classify the patient as stage IIIA but lymphadenectomy should be recommended in high-risk clinical stage I; for ovarian cancer, grading and amount of residual disease should be reported; for vulvar cancer, lymph node status should always be reported and for vaginal cancer urethral involvement should be added. The GCIG also recommends adoption of the WHO scoring system for gestational trophoblastic disease. These are well reasoned recommendations and it will be valuable for each gynaecological oncologist to read the details of this proposal.

## Obstetrics and Maternal–Fetal Medicine

Meta-analysis is a useful statistical method which combines the results of several studies that address a set of related research hypotheses. On page 75 Bar-Oz and colleagues from Toronto and Jerusalem used this method to look at the safety of quinolones in pregnancy with regard to major malformations. Quinolones are a group of antimicrobial agents which inhibit bacterial DNA synthesis. The authors found five studies meeting the inclusion criteria. The summary odds ratio for the included studies was 1.05 (95% CI 0.90–1.22) for major malformations and the odds ratios for stillbirth, preterm birth and low birth weight were non-significant. The conclusion is that quinolones taken during the first trimester of pregnancy do not appear to represent an increased risk to the fetus.

A twin pregnancy consisting of complete hydatiform mole and coexistent fetus (CHM&CF) is a rare and challenging condition. On page 84 Massardier and colleagues from Lyon, France, report a retrospective study of 14 cases of CHM&CF taken from the records of the French Trophoblastic Disease Centre between 1999 and 2006. Seven patients were diagnosed as gestational trophoplastic neoplasia (GTN). No woman died but there was a variable outcome of pregnancy. In eight cases the pregnancy was terminated and in six it was allowed to continue. In three of these six cases an abortion or intrauterine death occurred. Three women had live births between 25 and 38 weeks' gestation but one baby died at the age of 3 days. Continuation of pregnancy did not increase the risk of GTN but patients should be aware of the potentially high risk of developing GTN as well as the low favourable outcome regarding the fetus.

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Many years ago spontaneous contractions of myometrial strips were studied by researchers looking for drugs that could inhibit uterine activity. At that time beta-mimetics were developed for stopping premature labour and excessive contractions during delivery. The mechanisms underlying the spontaneous contractions, however, were not well understood. The paper on page 79 from Hutchings and colleagues from Brussels and Leuven sheds new light on this process. They studied spontaneous contractility of human myometrial strips obtained at term elective caesarean section and they used apyrase VI to decrease extracellular ATP levels. The strips responded with a dose dependent decrease in contractile frequency but not force. This work may eventually be the basis for developing new drugs to stop premature labour without the side effects that presently accompany tocolytic therapy.

## Gynaecology and gynaecological oncology

Treatment of endometriosis is focussed on the total removal of estrogen dependent external uterine tissue by operation or by drugs which exert their effects at different levels of the pituitary-ovarian axis. GnRH analogues or progestogens are currently used to reduce or counteract the effects of oestrogens on the tissue. A new approach is the application of inhibitors of aromatase, a key enzyme in the synthesis of estrogens. Verma and Konje from Leicester, UK, (page 112) used an aromatase inhibitor in four cases of refractory endometriosis-related pelvic pain. There was marked improvement in pain scores, and no changes in hormone levels and bone scan scores were observed. We look forward to receiving more reports on this novel therapeutic scheme.

The reported frequency of adenomyosis in hysterectomy performed for benign conditions varies in the literature between 5% and 70%. This wide range was questioned and clarified by a prospective investigation conducted by Parazzini and colleagues from Milan, Genoa and Cagliari, Italy (page 103). They investigated 820 patients who underwent hysterectomy for benign gynaecological conditions in 18 gynaecological departments. Adenomyosis was identified in 231 cases (28.2%). In women reporting one or more induced abortions the odds ratio of adenomyosis was 1.9 (95% CI 1.2–2.8). This is an interesting observation which we think needs further clarification.

The method used to treat uterine fibroids – surgical removal by laparotomy, laparoscopic surgery or hystero-resectoscopy – depends on the location and the size of fibroids and whether complaints are associated with the disease. Magnetic resonance-guided focused ultrasound surgery (MRgFUS) is a new approach to treating myomas and is described by Zaher and colleagues from London on page 98. It is a completely non-invasive method applied in outpatients and allows the woman to return to work within 24 h. Initial selection criteria were restrictive but the authors now use more relaxed criteria. They report a retrospective analysis of 144 patients seeking minimally invasive treatment options. Using the new criteria, eligibility and technical suitability were 100% and 70%, respectively. The authors expect that this will lead to a larger pool of patients for whom MRgFUS is a viable treatment option.

Carcinosarcoma of the uterus is a rare disease accounting for about 5% of all uterine malignancies. Galaal and colleagues from Gateshead, UK, identified a total of 93 women treated between January 1960 and July 2002 at the Northern Gynaecological Oncology Centre in England. The median age was 67 years. Vaginal bleeding was the first symptom in 85% of cases, followed by pelvic mass in 45% and abdominal pain in 38%. There was extrauterine spread at surgery in 54% and this had a major impact on the 5-year survival rate, which was 33% overall. Importantly, systemic adjuvant therapy was not associated with improved survival.

How should we train doctors in emergency gynaecological ultrasound examinations, to improve the quality of the scan? A proposal is given by Salomon and colleagues from Poissy, France, on page 116. They aimed to develop and evaluate the feasibility of an image-based scoring method for the evaluation of standardised images, and they were successful. A quality control policy for gynaecological emergencies based on image scoring is feasible and allows for good inter- and intra-reviewer reproducibility. This paper is worth reading as a potential way of improving the service in an important but often neglected area of gynaecology.

## Gynaecological urology

In the treatment of urinary stress incontinence the application of the tension free vaginal tape (TVT) has been a real success story. The positioning of the tape, however, was not always free of complications and therefore other methods such as the tension free obturator tape (TOT) have been proposed and have reduced the complication rate to a great extent. The new TVT-S system (tension free vaginal tape secure system) described by Martan and colleagues from Prague on page 121 was aimed at reducing the invasiveness of the tape procedure. The authors report a series of 85 women with previously untreated urinary incontinence. After operation 62% of these patients were completely dry and 25% were improved. This interesting article describes the pros and cons of the new method very critically.

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