European Journal of Obstetrics & Gynecology and Reproductive Biology 144 (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

The stillbirth rate attracts less attention in European countries than the perinatal mortality rate (PMR), which also includes neonatal deaths. Nevertheless the stillbirth rate may be the better guide to the quality of maternity care. We focus on the PMR because adverse events in pregnancy may lead to death after delivery as well as to stillbirth but the PMR may give us false reassurance about how well we are doing. In the UK in recent years there has been a slow but steady fall in the PMR which has been due entirely to a reduction in neonatal deaths, largely as a result of improving paediatric care of preterm babies. By contrast, the UK stillbirth rate has remained unchanged since the year 2000 (www.cemach.org.uk/Publications/CEMACH-Publications/Maternal-and-Perinatal-Health.aspx).

This fact has attracted the attention of the national media, thanks to a lay charity. The Stillbirth and Neonatal Death Society (SANDS), founded to support bereaved parents, became concerned at the lack of improvement and launched an action campaign. Called "Why17?", the campaign highlights the fact that every day there are 17 stillbirths or neonatal deaths in the UK—ten times the number of cot deaths. The Department of Health – and indeed many professionals – seem to accept that nothing can be done about this. In official statistics over 50% of stillbirths are dismissed as "unexplained". Various papers, some quite outspoken, have been written about this in medical journals but it is likely that pressure from the public will be more effective in stimulating a change in attitudes. We hope so.

What's New?

The vaginal route is widely agreed to be the best method of carrying out hysterectomy but in practice 60% of hysterectomies for benign disease are carried out abdominally. This figure is changing because of laparoscopy, which offers a variety of options ranging from laparoscopic-assisted vaginal hysterectomy (in which only the upper pedicles are secured laparoscopically) to total laparoscopic hysterectomy (TLH). In TLH the uterus may be morcellated and removed via the abdominal ports, or removed vaginally after laparoscopic colpotomy. On page 76 Mueller and colleagues from Erlangen, Germany, report a comparison of TLH and laparoscopic-assisted supravaginal hysterectomy and conclude that the two procedures are comparable for women with leiomyomata.

Older gynaecologists sometimes quietly ask whether there is any real advantage to these new techniques. In our review on page 3, Walsh and colleagues from Cambridge, England, report a meta-analysis of randomised controlled trials comparing TLH with total abdominal hysterectomy (TAH). They conclude that TLH is associated with fewer perioperative complications, less blood loss and a shorter hospital stay but that the operating time is significantly longer. Studies are still too small to reach a conclusion about major complications and the authors comment that more investigation is needed to follow up recent suggestions that there may be a difference in the long-term incidence of pelvic organ prolapse.

Normally we publish case reports of rare conditions as "Brief Communications" but occasionally we over-ride our own policy, and this month we publish a longer report and review of umbilical cord haemangioma by Papadopoulos and colleagues of Patras, Greece (page 8). The authors followed their patient through pregnancy with Doppler flow studies and found increasing resistance of the umbilical artery from 32 weeks onwards. In their review of 35 published cases they found a link with perinatal mortality although the risk cannot be accurately determined. Regarding clinical management, they recommend close follow-up with Doppler studies of the part of the umbilical artery within the tumour, and consideration of delivery if the resistance increases.

Obstetrics and Maternal–Fetal Medicine

The organisation of maternity care involves obstetricians, midwives, anaesthetists, other specialists, laboratory services and, crucially, paediatricians. To some extent it varies from country to country. In France maternity units are classified into three levels according primarily to the availability of neonatal services. Women can choose where to deliver and some base this decision on availability of perinatal technology. On page 21 Le Ray and colleagues, writing on behalf of the PREMODA study group, report on a cohort of 3652 infants born to low-risk nulliparas. Babies delivered in level 1 units were less likely to be admitted to neonatal care than those in level 2 or 3 units, but those who were admitted from level 1 units had more severe morbidity. The results support the suggestion that intervention is more likely in higher level units, an idea which is persuading planners in some countries to keep low risk women away from high-level units and indeed away from obstetricians. The French authors comment, however, that there may be a higher level of neonatal mortality in level 1 units. Predicting risk is no easy matter and it is worth noting that in this study the "low risk" group was defined retrospectively.

It is now almost half a century since the combined oral contraceptive pill was first approved for use in the USA. It is still popular and is said to be used by about 100 million women worldwide. The last 50 years have seen much controversy about its effects on women's health but it now seems clear that its benefits

0301-2115/$ – see front matter © 2009 Published by Elsevier Ireland Ltd.
doi:10.1016/j.ejogrb.2009.03.001

include an overall reduction in the incidence of cancer, estimated in a large UK cohort study to be 45 per 100 000 woman years. Nevertheless caution is still necessary about its effects on pregnancy. On page 40 Chen and colleagues from Ottawa and Shanghai report a cohort study of 1540 pregnant Canadian women who had used the pill within 3 months before their last menstrual period (LMP). Use within 30 days before the LMP increased the risk of preterm birth and low birth weight, but there was no increased risk if pill use stopped more than 31 days before the LMP. Standard advice has been to leave some time between stopping the pill and trying for pregnancy and it is good to have this advice confirmed by precise data.

Reproductive Medicine and Endocrinology

Assisted conception clinics have been under pressure to reduce the number of embryos reimplanted in individual women and this has increased after the furore over the octuplets delivered in California in January 2009. Most codes of practice, however, are voluntary and it has been reported that only 20% of clinics in the USA abide by the American Society of Reproductive Medicine's guideline. Doctors who believe that multiple-embryo transfers increase the chances of success may be convinced otherwise by the report on page 54 by Yli-Kuha and colleagues from Finland. In that country the number of single-embryo transfers has increased substantially since 1995, when they constituted only 10% of the total. In 2005 over 50% of transfers involved a single embryo and the remainder involved only two. The authors compared pregnancy rates in 1995 and 2005 and report that success rates have remained stable and indeed pregnancy rates have increased among women aged 40 or more. They comment that success rates are similar on both sides of the Atlantic although as many as 32% of American cycles involve the transfer of four or more embryos compared with 6% in Europe.

Gynaecology and Gynaecological Oncology

Vulvovaginal candidiasis is a common condition worldwide and for a substantial minority of women it is a recurrent problem. Two papers in this issue address this topic in different ways. On page 68 Ahmad and Khan from Aligarh, India, report a prospective study of 1050 women aged 15–60 attending the outpatient clinic with symptoms of vaginal discharge or irritation. Swabs were taken and 215 tested positive for candida. Risk factors included pregnancy, antibiotic use, oral contraceptive use and high parity. A similar 20% incidence of positive swabs has been reported in other countries, raising the question of why some women are more susceptible than others to symptomatic candidosis. It seems likely that this is related to the immune response. On page 59 Weissenbacher and colleagues from Germany and the USA report on immune mediators in the vaginal fluid of women with recurring vulvovaginal candidosis (RVVC). They used polymerase chain reaction as well as culture to detect candida and found no relationship with interleukins (IL) 5 and 13 or with total IgE. Symptomatic women with a history of RVVC, however, had raised concentrations of IL-4, prostaglandin E2 (PGE2) and candida-specific IgE, compared to asymptomatic women. The authors conclude that localised vaginal immunosuppression may be the cause of their symptoms and that raised PGE2 may be a consequence of a local allergic response. This, they suggest, raises the possibility of treatment with an antihistamine or a prostaglandin synthetase inhibitor.

Gynaecological Urology

Surgery always involves a balance of benefits and risks and the two papers in this section illustrate different views of this balance. On page 85 Jha and colleagues from Sheffield, UK, report a 3-month postoperative review of 100 women undergoing a tension-free vaginal tape (TVT) procedure. They found that women with more severe pre-operative stress urinary incontinence (SUI) had the greatest improvement and, unlike some previous studies, that age and co-existing symptoms did not affect the outcome. TVT has established itself as a procedure with a low complication rate and this report does not include complications. By contrast, Bjelic-Radisic and colleagues from Austria focus mainly on the complications of the more challenging procedure of posterior intravaginal slingplasty (page 88). In 2003 the Austrian Urogynaecology Working Group set up a registry for these procedures and the present paper includes a total of 577 patients operated in 14 centres between 2001 and 2006. Almost all the slingplasties were done in conjunction with other procedures. The authors report that there were intraoperative complications in 2.8% of procedures, 9.4% of the patients required reoperation and vaginal tape exposure was seen in 8.7%. Nevertheless functional and anatomical results were excellent or good in 83% and 88% of patients, respectively. The latter figure, 88%, is also the proportion of patients who had a 20-point improvement in SUI in Jha's study.

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