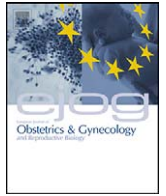


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Editors' highlights

Although this issue looks no different from last month's, there has been a major change behind the scenes. Until now the Journal's editorial structure has been based on geography, with Regional Receiving Editors for Mediterranean countries, Scandinavian countries, and so on. This was appropriate for a journal covering a continent which, although small in terms of land mass, has a rich variety of languages, cultures and indeed styles of medical practice. In the past, local contact was essential and new research was presented at regional or national meetings which covered all branches of our specialty.

Recent years, however, have seen two major developments—subspecialisation and the Internet. Colleagues who work in different countries can communicate easily and cutting-edge innovations are now announced at meetings of specialist societies. At the same time electronic communication has revolutionised the work of journal editors, and the EJOGRB's panel of expert reviewers has gone global. The Editors and Publisher have therefore decided that the Journal's team should now be specialty-based, with two editors for maternal–fetal medicine, two for gynaecological oncology, etc. We believe this will provide a better service to authors and readers.

We wish to record our deep gratitude to the Regional Editors, Peter Bosze, Jacques Lansac, Titiano Maggino and Nils-Otto Sjoberg, who have made considerable contributions to the Journal over many years. They have been delightful company at the annual Editors' meetings, as have Anga Arunkalaivanan and Kuldip Singh, the Advisory Board Editors who are now joining the Editorial Board. We thank all these colleagues and we welcome our new Specialty Editors—Linda Cardozo, Henri Marret and Peter O'Donovan, who are joining the Journal, and Risto Erkkola, Sean Kehoe, Philip Owen and Wiebren Tjalma, who were formerly Advisory Board Editors. As the chairs around the editorial table are quietly rearranged we hope the new team will enjoy this fascinating work as much as their predecessors did.

What's new?

We mentioned variation in practice across Europe. An example is breast disease, which is the remit of the gynaecologist in some countries but not in others. Europe has around 430,000 new cases of breast cancer each year – more than double the total of all other gynaecological cancers – and rates in Eastern Europe are rising rapidly towards western levels. In our first review (page 3) [Ekmektzoglou and colleagues](#) from Athens discuss the history of breast cancer. It was described in ancient Egypt and named by

Hippocrates but real progress in our understanding did not begin until the 19th century. Perhaps the most interesting chapter in this story is the last half-century, as advances in our own lifetime are placed into their historical context.

By contrast, preimplantation genetic diagnosis (PGD), the subject of our second review, is less than twenty years old, having been first developed in 1990. On page 9 [Basille and colleagues](#) from Paris describe the procedure itself and the lack of any European consensus regarding its legal status. In Germany and Italy it is banned; in France and the UK it is regulated, and in Finland and Portugal there are no legal restrictions. One of its controversial aspects is the selection of an embryo to provide stem cells for an existing child, and another is preimplantation genetic screening (PGS), which is illegal in France. PGS is presently used to look for aneuploidy but the prospect has been raised of screening embryos for multiple diseases. Ethical questions abound, and one of the few areas of consensus in Europe is a ban on sex selection for non-medical reasons.

Laparoscopic surgery, a little older than PGD, is another fast-moving field in which new technology is being used for a widening range of applications. Until recently few would have thought the technique could be applied to myomectomy but [Jin and colleagues](#) from Wenzhou, China, have identified six randomised studies of laparoscopic versus open myomectomy in their meta-analysis on page 14. They found that the laparoscopic approach involves less blood loss and quicker recovery, though the operating time is longer. It is preferable to open surgery, say the authors, but only when performed by suitably specialised surgeons on selected patients.

Our fourth review looks at the problem of recurrent miscarriage (RM) from an unfamiliar angle. RM is known to be linked with antiphospholipid antibodies (aPL) but women with RM have also been found to have raised levels of circulating microparticles. These are microvesicles released from the cell membrane during apoptosis or cell activation, and arise mainly but not exclusively from platelets. On page 22 [Alijotas-Reig and colleagues](#) from Barcelona, Spain, discuss possible relationships between aPL, endothelial cell activation, microparticles and poor obstetric outcome. We are still a long way from therapeutic application of this knowledge but perhaps a step closer to having all the pieces of this jigsaw puzzle.

Obstetrics and maternal–fetal medicine

It has been known for many years that preconceptional use of folic acid reduces the risk of neural tube defects but unfortunately

only a minority of women take folic acid before conception. **Paulik and colleagues** investigated this issue with a questionnaire study in Szeged, Hungary (page 49). Overall, more than 80% of the women in this study had planned their pregnancy but only 30% took folic acid before pregnancy. Women with unplanned pregnancies were much less likely than others to have taken folic acid, which is not surprising. Although regular folic acid intake has been recommended to pregnant women in Hungary since the 1980s, most women do not take it in the months before conception, or indeed in early pregnancy. The authors suggest a media campaign and supplementation of flour with folic acid, but they also comment that health professionals need to play a role in educating women.

Controversy over whether induced abortion increases the risk of subsequent pregnancy loss has continued for at least forty years. Over that time, methods have changed and medical abortion has become more common. On page 53 **Winer and colleagues** state that there are about 200,000 abortions in France each year and most are now performed with misoprostol, alone or combined with mifepristone. Previous research on surgical abortion has concluded that the risk of subsequent pregnancy loss or preterm delivery is increased by repeated abortions or second trimester abortions. The French team conducted a case-control study of 245 singleton pregnancies delivering at 16–36 weeks and concluded that a woman with a history of exposure to misoprostol had a non-significant increased risk of late abortion or preterm delivery. This is another reason for suggesting that when abortion is necessary it should be medical rather than surgical.

Monitoring descent of the fetal head in the second stage is an essential part of labour management but clinical assessment is subjective and research has shown poor inter-observer agreement. On page 65 **Awan and colleagues** from Liverpool, UK, describe a simple plastic device for making this assessment more objective. The "StationMaster" is based on the Amnihook and is designed to measure the distance between the leading part of the fetal head and the fourchette. This first study, using a model fetal head and a mannequin, indicates that it is more accurate than digital examination. *In vivo* studies are now required but it is encouraging to see attention being paid, and science being applied, to this important aspect of obstetric practice.

Reproductive medicine and endocrinology

Much research on the menopause has been on its links with serious disease such as cancer and osteoporosis but there is increasing interest in "minor" symptoms such as insomnia, which has been reported in up to 83% of post-menopausal women. On page 81 **Hachul and colleagues** from Sao Paulo, Brazil, report a study of thirty women attending a menopause clinic, fourteen of whom were in the early (<5 years) post-menopause and the rest in the late (>5 years) post-menopause. All subjects underwent

polysomnography, which involves an electroencephogram, electrooculogram, electromyography, monitoring of breathing and pulse oximetry. None of these objective measurements differed between the groups but subjective symptoms did. Complaints of lack of memory were more common in the "early" group and sleepiness was more common in the "late" group. The authors recommend that more attention should be paid to differences in symptoms at different post-menopausal stages. The editors would be interested to see a similar study with male controls.

Gynaecology and gynaecological oncology

Cervical cancer is the subject of two papers in this issue. The introduction of vaccines against this disease has been a revolutionary change, scientifically and socially. To make an informed decision about vaccination for themselves or their daughters, women need a good understanding about the cause of this cancer. One year ago, **Donders and colleagues** from Belgium published a study of women's knowledge of cervix cancer, human papilloma virus (HPV) and HPV vaccination when the vaccine was introduced in Belgium. Now they have repeated the study (page 93). They found a dramatic improvement, with knowledge about the role of HPV and the presence of a vaccine rising from 50% in 2007 to over 80% in 2008. Educational level no longer affected knowledge or willingness to accept the vaccine. Unfortunately, however, the cost of vaccination is a major barrier to its acceptance among the people most at risk—women aged 16–25. This is unacceptable and the authors hope that policy makers and industry take note of this message.

Vaccination should protect against cervical adenocarcinoma (AC) as well as squamous cell carcinoma. AC has increased in many countries as squamous cell carcinoma has fallen, and in the United States ACs now make up more than 20% of all cervical cancer cases diagnosed each year. Management of adenocarcinoma in situ (AIS) has been controversial. Standard treatment is hysterectomy when future child-bearing is not an issue but the increasing incidence in young women has brought calls for conservative treatment. Loop excision has been regarded as inferior to cold-knife conisation because of higher recurrence rates but on page 100 **Kim and colleagues** from Seoul review 78 patients treated with a loop electrosurgical excision procedure (LEEP) between 1992 and 2008. Of these, 31 had positive excision margins and all but two underwent hysterectomy. Of the 47 with negative margins, 30 underwent subsequent hysterectomy and residual AIS was found in five cases. After a mean follow-up of 28 months no recurrences have been found in the 19 patients who did not undergo hysterectomy. The authors conclude that conservative management seems to be feasible but careful surveillance is required.

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