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# Editors' highlights

With summer gone and Christmas still to come, November is a month of long dark nights in Europe. These are good for academic work and discussion, and in some countries this is a busy time for local and regional meetings. In London the Academic Association of Obstetrics and Gynaecology (AAOG) is about to hold its fourth annual meeting. It evolved from an older organisation, the Association of Professors of Obstetrics and Gynaecology, with the purpose of being a voice for academics in our specialty in the British Isles. The AAOG works closely with the Royal College of Obstetricians and Gynaecologists, and as well as developing research networks and sharing good practice in education, a major aim is recruiting and developing new academics for the future. We all know that a specialty focus is important in attracting clinicians into academic work but universities are putting this at risk as departments are combined for the sake of efficiency. AAOG is a young organisation with talent and energy, and we wish it well. Already it includes the UK and Ireland, and as it grows we hope its influence in Europe will extend. Further details can be found at www.rcog.org.uk under "Our profession".

## What's new?

Since the early days of abdominal surgery it has been normal practice to close the peritoneum but during the 1990s this tradition was questioned. A Cochrane review of short-term studies recommended non-closure because of reduced operative time, reduced infection rates and many other apparent advantages. Nevertheless many surgeons were unwilling to change their practice and their reluctance seemed justified when reports appeared of complications such as adhesion formation and bowel problems after non-closure. These stimulated further longer term studies which are reviewed by Premkumar and colleagues from Southampton and Sheffield, UK on page 3. The authors identified 11 studies, of which 3 met their inclusion criteria. Two of these were randomised, and meta-analysis of these showed a significantly increased likelihood of adhesion formation with non-closure of the peritoneum. It is reassuring to see clinicians' perceptions, so often dismissed as unreliable, being supported by objective analysis, in this case at least.

Breast cancer complicates 1 in 3000 pregnancies and the median gestational age at diagnosis is 21 weeks. The dilemmas that this poses for patients and clinicians are discussed on page 9 by Vinatier and colleagues from Lille, France. The authors comment that there is a paucity of prospective studies, but they conclude that surgery can be performed as in the non-pregnant patient, that chemotherapy is allowed after the first trimester, and that radiotherapy and endocrine or antibody treatment must be delayed until after delivery. The major problem with this condition is that pregnancy delays the diagnosis, often because symptoms are ignored by patients and doctors. The authors urge that workup of breast symptoms in pregnant women should be aggressive to expedite diagnosis and multidisciplinary treatment.

Post-partum haemorrhage (PPH) is the leading cause of maternal mortality across the globe. Even in developed countries, where oxytocics are given in the third stage of labour, reviews of severe maternal morbidity show that life-threatening PPH still occurs in around 1 in 300 deliveries, though it is usually treated successfully. Studies have clearly shown that routine use of oxytocic agents at delivery for the prevention of uterine atony reduces the risk of PPH, but the ideal oxytocic agent is elusive. On page 15 Werner Rath from Aachen, Germany, presents a review of carbetocin, a synthetic analogue of oxytocin with a half-life about 4–10 times longer than that reported for oxytocin. In double-blind trials in high-risk women it proved superior to oxytocin, with a similar incidence of side effects. It is still contraindicated in pre-eclampsia but there are suggestions that it may become useful in this group also. Further trials are needed in low-risk women and in developing countries.

Chronic pelvic pain is a difficult condition which may have surgical or urological causes as well as gynaecological ones. Patients may be passed from one specialist to another in the hope of finding a cause and 60% never receive a specific diagnosis. On page 21 Montenegro and colleagues from Sao Paolo, Brazil, review the role of abdominal myofascial pain syndrome (AMPS), and suggest that it may account for 15% of cases. AMPS is intense and profound pain in the abdominal region originating from myofascial triggering points. It is usually diagnosed by palpation. Treatment is multidisciplinary and may involve pharmacotherapy, needling, trigger point injections or manual therapy. Published data, say the authors, are scarce and they call for more studies to verify the best therapeutic options.

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## Obstetrics and maternal–fetal medicine

It is well known that pregnancy induces postural changes in the mother but it comes as a surprise to find that these can be measured. Oliveira and colleagues from Brazil, Italy and UK (page 25) carried out stabilometric tests, measuring postural sway in two directions, on twenty women at three stages of pregnancy. They found that postural control significantly changed throughout pregnancy, but only when the visual input was suppressed or the support base was reduced – i.e. when the eyes were closed or the feet were together. These findings are relevant to the risks of back pain or falls. As more women try to work normally until late in pregnancy it is important for them to appreciate that although pregnancy is not an illness it does produce bodily changes which require adaptation.

Recurrent pregnancy loss (RPL) affects 1% of women and in many cases no cause is found. RPL is associated with various conditions including antiphospholipid syndrome, and alterations in several serum markers such as inhibin. Relaxin, which has important roles in reproduction, has not yet been studied in this condition. On page 41 Anumba and colleagues from Sheffield, UK, report a study of 20 pregnant women with a history of RPL, compared with pregnant controls. At all stages of pregnancy serum levels of relaxin were lower in the study group. Relaxin is produced mainly by reproductive tract tissue and regulates blood flow to the endometrium, and the authors hypothesise that failure of this regulation is why low relaxin levels cause pregnancy failure. Interestingly, umbilical cord levels of relaxin were four times higher in the study group than in the controls, suggesting a compensatory increase in fetal relaxin through some as yet unidentified feedback mechanism. These results are a reminder, if one is necessary, of how much is still unknown about fetal physiology.

The dangers of smoking are well publicized but nevertheless many women continue to smoke during pregnancy. In France, 30% of pregnant women smoke and indeed abstinence during pregnancy is more likely among male partners than among women themselves. Baha and Le Faou from Paris studied 682 pregnant smokers registered on the French national smoking cessation database. Sixteen percent of these smokers stopped during pregnancy but almost 60% never returned to a cessation service. These women, say the authors, were not motivated to stop but were more interested in maintaining a reduced tobacco consumption for stress relief. The authors call for more co-ordinated efforts between antenatal care providers and smoking treatment specialists to improve women's motivation. Sadly, co-ordination among services – whether for smoking cessation, child protection or other important issues – is something many countries find hard to achieve.

## Reproductive medicine and endocrinology

We learned at medical school that "occupational diseases" included lung disease among coal miners, compression sickness in divers and infections contracted by those who work with animals. Hairdressers were not on the list and menstrual disorders were in a different chapter of the textbook. On page 61 however, Ronda and colleagues from Spain and Norway point out that hairdressers work with a wide variety of chemical products which are designed for external use but which may be inhaled or absorbed through the skin. They compared 310 female hairdressers with a control group of 310 shop assistants and office workers, and found that the rates of menstrual disorders and subfertility were about twice as high among hairdressers. The authors comment that although exposure to chemicals is the most likely cause, hairdressers also spend much of their working day standing and are frequently exposed to stressful situations, and further research is needed to explain this association.

## Gynaecology and gynaecological oncology

Ablation of the endometrium is now a widely used treatment for menorrhagia, and second generation procedures are officially recommended in England as preferable to hysterectomy. Residual endometrium, however, almost always exists after ablation and if further bleeding occurs assessment of the residual endometrium may be difficult. Clinicians often rely on ultrasound and there have been no studies on the feasibility of office endometrial sampling. On page 69 Ahonkallio and colleagues from Oulu, Finland, present a study of 57 women who responded to an invitation for clinical examination 3–10 years (mean 6 years) after endometrial ablation. Seventeen were amenorrhoeic and 3 still had heavy periods. On ultrasound examination, the endometrial thickness was 4.5 mm in the amenorrhoeic women and 5.6 mm in those who still had normal periods. Pipelle endometrial sampling was successful in 44 women (77%). On sonohysterography the uterine cavity distended normally in only nine women, and in ten the catheter did not enter the uterine cavity at all. The study confirms that thermal ablation makes subsequent assessment of abnormal uterine bleeding difficult and the authors conclude that the treatment cannot be recommended for patients with high risk factors for endometrial cancer.

National guidelines on cancer treatment are now in place in several countries but there is concern about how well they are being followed. On page 78 van der Aa and colleagues describe variations in treatment and survival after cervical cancer in two regions of The Netherlands and relate these to adherence to national guidelines published by the Netherlands Working Group Gynaecology Oncology. The authors conclude that treatment recommendations were more likely to be followed in patients with less advanced disease (FIGO stages IB-IIA) and that elderly patients received different treatment from younger patients. In medical practice there are good arguments for individualizing treatment rather than blindly following guidelines but in oncology there is clear evidence that patients treated according to guidelines have better survival rates. The authors call for age-specific guidelines.

## Gynaecological urology

Prolapse surgery is a common procedure. In the USA 200,000 of these operations are performed annually, and almost 30% of patients require further surgery within four years of the primary procedure. The biggest technical change in recent years has been the use of mesh, which may improve efficacy but carries a risk of complications, with uncertainty about long-term results. Many different types of mesh are being used and in the UK the National Institute for Health and Clinical Excellence has called for more research on the different types. On page 106 Sergent and colleagues from Rouen, France, report an animal study comparing the two most widely used synthetic materials in pelvic floor surgery, polypropylene (PP) and polyester (PET). They report that although PET appears unsuited for vaginal procedures because it is more sensitive to infectious complications, it seems to be the optimal material as regards mechanical properties. The ideal balance between safety and efficacy remains elusive.

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