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Editor's highlights

Each European country has its own professional association of obstetricians and gynaecologists, looking after the interests of women and specialists in that country. Language barriers often make interaction difficult but many of these organisations are becoming more international in outlook. The French College of Gynaecologists and Obstetricians, for example, recently published one of its guidelines, translated into English, in this Journal and we shall be publishing another one, on stress urinary incontinence, next month. In the UK, the Royal College of Obstetricians and Gynaecologists (RCOG) has translated ten of its guidelines into Russian and these are now available on its website. The RCOG is working to make them more accessible to Russian-speakers who search the web using the Cyrillic alphabet. Technical details like this are essential to effective international co-operation.

The International Office of the RCOG, in addition to its long-established links outside Europe, is liaising increasingly with Eastern Europe. There was a combined meeting in Lithuania last year and another in Kosovo last month. Ultimately, international co-operation depends on individuals. Dr. Tony Falconer, the Senior Vice-President (International) of the RCOG, recently became its president-elect, and the College's outgoing President, Professor Sir Sabaratnam Arulkumaran, is the president-elect of FIGO. European countries have a great deal of specialist expertise to share with one another as well as with the rest of the world, and this must be to the benefit of our patients.

What's new?

Although peritoneal adhesions can cause problems for both male and female patients, the female reproductive system is particularly susceptible to their adverse long-term effects. We recently published a review of experimental work on non-barrier agents for their prevention and in this issue we present a comprehensive clinical review of the prevention of postoperative adhesions. Remah Kamel of Jazan, Saudi Arabia, discusses surgical techniques and adjuvant methods and points out that although a good surgical technique is a crucial part of adhesion prevention, technique alone cannot eliminate them. The author recommends, among other measures, the use of heparin-treated Interceed on raw surfaces at laparotomy and, during laparoscopy, irrigation with warm Ringer lactate followed by application of SprayGel at the end of the procedure.

A related study appears at page 180 where Hackethal and colleagues report on the awareness of adhesions and their consequences among gynaecologists in Germany. A questionnaire was sent to the heads of all 833 gynaecological departments and was returned by 279 of them. Awareness was high: more than 60% of interviewed gynaecologists believed that postsurgical adhesions account for major morbidity and more than 80% told their patients about the risk of prior adhesion formation. Nevertheless there was uncertainty about prophylactic strategies, and only 22% used anti-adhesion products in clinical practice. We suspect that this reflects the practice in most countries.

Our second review is based around a case report of a fetus diagnosed with a rare genetic abnormality – an unbalanced translocation from the subtelomeric region of chromosome 6p to the subtelomeric region of chromosome 16q. Puhl and colleagues from Mainz, Germany, present a detailed review of similar cases in the literature. The advent of routine mid-trimester ultrasound screening has meant that women expecting reassurance that their fetus is normal now face the chance of discovering anatomical abnormalities which may have major implications. Some parents then have to make the harrowing decision about whether or not to continue with the pregnancy. Genetic investigation which reveals a rare abnormality can make the decision even more complex, and reviews like this are essential to help such patients.

Obstetrics and maternal–fetal medicine

Drug abuse is a common problem in many European countries and most drug users are of reproductive age. Helping these patients is a difficult task and pregnant drug users require care by a multidisciplinary team. Social problems are often present and their effects on pregnancy may be hard to distinguish from the effects of the drug abuse. This distinction is clarified on page 137 by Pinto and colleagues from Liverpool, UK, who carried out a retrospective cohort study of 247 drug-using women and 741 controls matched by year of delivery and district of residence. Among the drug-using women there was a more than twofold increase in the risk of preterm birth and an even greater increase in the risk of growth restriction. The incidence of low birth weight was 30.8% in this group. Placental abruption was also increased but the incidence of pre-eclampsia was extremely low, even after controlling for the effect of smoking. The authors point out that this is the first study to highlight the markedly reduced risk of pre-eclampsia, and that further research is needed on its biological cause.

The effects of vaginal delivery on the pelvic floor are examined in this section of the Journal and also in the section on urogynaecology. It used to be taught that elective episiotomy would reduce the risk of obstetric anal sphincter injury (OASI) but in recent years this idea has been questioned and there has been increasing tolerance of "natural" tears. On page 142 Revicky and colleagues describe a retrospective study of 10,314 vaginal deliveries with cephalic presentation in Norwich, UK. The

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frequency of anal sphincter lacerations was 3.2%. OASI was associated with parity, birth weight, method of delivery and shoulder dystocia, and was 1.4 times more likely in deliveries without a mediolateral episiotomy. The incidence of OASI rose between 2005 and 2007 but, as the authors point out, this increase may be due either to a change in practice or to better identification of tears, and a randomized controlled trial would be needed to confirm a protective effect of episiotomy.

Instrumental delivery may cause pelvic floor damage but the anxiety that is often present in the delivery room is more about the condition of the baby and about whether delivery can be achieved successfully. Reducing this tension is discussed by Bahl and colleagues from Bristol, UK, and Dublin, who studied the non-technical skills required by obstetrians (page 147). The authors point out that the decision to perform instrumental delivery is usually taken in the second stage of labour, that the mother is awake and that her co-operation is essential. They interviewed obstetricians and midwives, performed video recording of deliveries in a simulated setting, and compiled a list of skills which were classified into seven headings. Four headings, including decision-making and teamwork, were similar to categories identified in surgery but three were unique to obstetrics – professional relationship with the woman, maintaining professional behaviour and cross-monitoring of performance. This interesting paper will be read by even the most experienced obstetrician with a feeling of thoughtful reflection.

Reproductive medicine and endocrinology

Intracytoplasmic sperm injection (ICSI) is familiar to the general public as it is often shown on television to illustrate assisted reproduction technology (ART). Nevertheless there are still concerns about whether it can be completely safe to over-ride the natural processes of sperm attachment and oocyte penetration. These are addressed on page 160 by Wen and colleagues from Canada and China, who report a retrospective study of 1044 infants conceived by IVF/ICSI at the Ottawa Fertility Centre from 1996 to 2005. These were compared with 1910 naturally conceived infants. Eleven (1.1%) of the infants conceived with ICSI had congenital heart defects compared with 0.4% of the naturally conceived infants. The difference was more obvious among mothers with obesity (BMI $>$ 30): in this group 3.6% of the infants conceived by ICSI, and none of the naturally conceived infants, had congenital heart defects. A link between obesity and birth defects has been reported before and requires further study.

One of the concerns of ART is to avoid multiple pregnancy. Selection of patients for single embryo transfer could be assisted by a method of predicting the chance of live birth. This point is made by Majumder and colleagues from Manchester, UK (page 166), who report a prospective study of 162 women undergoing their first IVF cycle. They measured serum anti-Mullerian hormone (AMH) concentrations and antral follicle counts (AFC) on day 3 of a pre-stimulation cycle. Both were significantly correlated with the numbers of oocytes retrieved and fertilised, and both were also correlated with the number of top quality embryos and the number frozen. Both had high negative predictive values for the occurrence of live birth, but the advantage of AMH is its measurement at any time in the cycle.

Gynaecology and gynaecological oncology

Cervical polyps affect up to 10% of women, mainly between the ages of 40 and 65. They may cause symptoms such as post-coital bleeding but are often asymptomatic in postmenopausal women. It is widely accepted that a cervical polyp requires removal with hysteroscopy or ultrasound examination to check for other polyps, but this is questioned by Younis and colleagues on page 190. The authors carried out a retrospective review of 988 women who had cervical polyps removed and examined at Ipswich Hospital, UK, between 2002 and 2008. All polyps were benign except two symptomatic polyps which showed high grade cervical intraepithelial neoplasia. In the 133 women who underwent further investigation because of the polyp, no significant pathology was found. The authors conclude that women with asymptomatic polyps do not require referral to a gynaecologist.

Treatment of endometriosis is the subject of two papers, one on surgery and one on medical therapy. Radosa and colleagues from Jena, Germany, report (page 195) a retrospective comparison of two laparoscopic treatments, coagulation and sharp excision, for intraperitoneal superficial endometriosis. They evaluated a total of 79 patients at a mean of 29 months' follow-up, investigating pain scores and surgically proven relapses. They found low pain scores in both groups, and a significantly lower recurrence rate in the coagulation group (2.8%) than in the excision group (18.6%). They caution that due to the non-randomised nature of the study, the results should be interpreted with care and prospective studies are needed. On page 199 Ferrero and colleagues from Italy report a prospective study of six women with colorectal endometriosis causing pain and intestinal symptoms but no bowel stenosis. A combination of letrozole (an aromatase inhibitor) and norethisterone given for 6 months reduced pain, and four patients said it reduced their gastrointestinal symptoms.

Gynaecological urology

Fear of pelvic floor damage makes some women seek elective caesarean section but there is still debate about the degree of risk of incontinence after delivery. Arrue and colleagues from San Sebastian, Spain, report (page 210) a prospective study of 396 women having their first vaginal delivery. The women were interviewed and examined at term and at 6 months postnatally. Fifteen per cent of those asymptomatic before pregnancy reported stress urinary incontinence (SUI) at 6 months. In most cases, however, it was slight or moderate and its impact on the quality of life was low. The type of delivery was not a risk factor, and the only factor independently associated with SUI at 6 months was incontinence at the end of pregnancy, suggesting that the mechanism may be related to changes occurring during pregnancy rather than at delivery itself.

J. Drife