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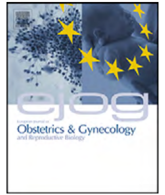

Editor's highlights

As the summer fades, and with it the memory of an excellent European performance in football's World Cup, many countries are facing a winter of economic austerity. Our specialty may not be first in line for cuts to funding – governments want people to keep having babies – but we cannot escape some of the effects of budget reductions. These bring risks. Staff in many public services are already thinly spread and overworked. If this process goes too far in the maternity services, it begins to threaten the low maternal and perinatal mortality rates that much of Europe takes for granted. As always, poor people are most at risk. On the academic front, research funding becomes even harder to find in tough economic times. We must all speak up to ensure that even when governments are struggling with debt, women's health remains a priority.

What's new?

Fetal medicine specialists put a great deal of effort into identifying and managing high-risk pregnancies but monitoring fetal growth restriction (FGR) is not an exact science. On page 3 Morris and colleagues from the UK and The Netherlands point out that "there is a lack of scientific consensus about the best diagnostic and monitoring strategies for predicting FGR and compromise of fetal wellbeing before birth". Doppler blood flow studies are widely used. Arterial Doppler provides information about, for example, placental function, and venous Doppler can quantify fetal cardiovascular compromise. Retrograde flow in the ductus venosus (DV) signifies the onset of overt cardiac failure, and some believe that DV Doppler is the best test for deciding when to deliver the fetus with FGR. Morris and colleagues conducted a systematic review and meta-analysis of 18 studies and they conclude that abnormal DV Doppler showed a moderate predictive accuracy for fetal compromise. They also comment that the meta-analysis was limited by significant heterogeneity. A European randomised controlled trial (www.trufflestudy.org) is now recruiting to determine the most appropriate threshold for timing delivery.

Urological problems are common in pregnancy, though we have the impression that hospital admission for pyelonephritis is more frequent in Eastern Europe than in the West. A comprehensive review from outside Europe is provided by Fiadjoe and colleagues from Townsville, Australia, on page 13. The authors discuss the physiological changes that can cause diagnostic confusion, with mild hydronephrosis occurring in up to 90% of pregnancies and urgency in 60% of pregnancies. The spectrum of disease ranges from asymptomatic bacteruria (in 2–8% of pregnancies) to renal failure and malignancy, and it includes trauma at delivery, nowadays most commonly seen in the developing world. It is interesting to read this wide-ranging review, with the overall message that with prompt evaluation and expeditious management, the prognosis is good.

Our third review, presented under the heading "European view", is the new French guideline on pregnancy in Turner syndrome. Such pregnancies used to be very rare because the syndrome normally includes ovarian dysgenesis, but as it spares the uterus, pregnancy can now be achieved by oocyte donation. Unfortunately, however, as many as 5–50% of women with Turner syndrome have a cardiovascular malformation, and 2% are at risk of death from aortic dissection or rupture. After the deaths of two women in France from this cause, the government asked the French College of Obstetricians and Gynaecologists to draw up the recommendations which we now publish on page 72. They are clinically based and very practical, covering all aspects of care from the pre-pregnancy check-up and discussion of contra-indications, to delivery and postnatal care. The final recommendation relates to the Turner Syndrome Registry, which we assume applies only in France, but otherwise this guideline will be useful worldwide.

Obstetrics and maternal-fetal medicine

Without guidelines, informed medical opinion is not always unanimous, and this is the subject of a study by Brown and colleagues from Birmingham, UK (page 25). Congenital lower urinary tract obstruction (LUTO) has an incidence of around 2.2 cases per 100,000 births and is diagnosed when antenatal ultrasound scans reveal a dilated fetal bladder, usually associated with oligohydramnios. The outcome may be perinatal death from pulmonary hypoplasia or survival with severe renal impairment. In utero vesico-amniotic shunting (VAS) may prevent these complications but evidence for its effectiveness is limited, and a multicentre randomised controlled trial (RCT) called "PLUTO" is now in progress. Clinicians' willingness to participate in any RCT is affected by their prior beliefs regarding the effectiveness of treatment, and these beliefs are what these authors investigated. They sent a questionnaire to 59 experts—fetal medicine practitioners, paediatric nephrologists and paediatric urologists. Despite low response rates, the results showed divergence of opinion among specialists, with fetal medicine specialists having the most optimistic beliefs regarding the effect of VAS on perinatal mortality. The trial will continue recruiting in 2010 and when the results are

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available the authors plan to contact the experts again to find out how the results have changed beliefs and clinical practice.

Preterm premature rupture of the membranes (PPROM) is responsible for about a third of all premature births and is a leading cause of perinatal morbidity and mortality. When amniotic fluid is being lost the obvious course of action is to plug the leak and/or replace the fluid. So far, however, all attempts at sealing the ruptured membranes have been relatively unsuccessful and repetitive amnioinfusions have shown only minimal benefit. On page 30 Tchirikova and colleagues from Mainz, Germany, report a novel treatment by long-term amnioinfusion through a subcutaneously implanted port system. After many years of development and testing in a fetal sheep model, the system was used in two women with PPROM. Implantation of the system was at the 23rd and 24th weeks, and management of the pregnancies also included tocolysis and betamethasone injections. The pregnancies were prolonged until the 29th and 30th weeks, respectively, and both children now appear to be developing normally. Prospective randomised trials are now required and are ongoing.

Reproductive medicine and endocrinology

Adnexal torsion has become more common with the introduction of superovulation as part of IVF treatment. Torsion is not always easy to diagnose and the treatment used to require emergency laparotomy, but it can now be treated laparoscopically. Laparoscopy in early pregnancy is generally safe but nevertheless carries some risks and is best avoided if possible. On page 60 Chang and colleagues from Seoul describe the use of ultrasound-guided transvaginal aspiration of the multiple luteal cysts in eight women presenting with adnexal torsion at between 4 and 9 weeks' gestation. The procedure was performed in the same manner as transvaginal oocyte retrieval. In two cases symptoms recurred, requiring laparoscopic detorsion, but the other six cases were treated with simple aspiration only. Normal ovarian blood flow was confirmed in the month after the procedure. One twin pregnancy was lost after laparoscopy but in the other seven women the outcome of the pregnancy was normal.

Cryopreservation of ovarian tissue is attracting increasing attention as an option for fertility preservation, either in patients about to undergo chemotherapy for malignant disease or in those with non-malignant diseases at high risk of loss of ovarian function. Laparoscopy is the least invasive method of harvesting ovarian tissue and on page 68 Mayerhofer and colleagues from Vienna review their experience in a retrospective cohort study of 85 patients treated between 1998 and 2008. In the sixty patients who underwent laparoscopy for ovarian tissue harvesting only, the median operating time was 30 min and the intraoperative course was uneventful. In one case, cells of a dysgerminoma were found in the cortical slice taken, and in one case there was sporadic contamination with *P. acnes*. The authors recommend that histological and microbiological testing of the tissue is mandatory. In three of their cases the only indication for ovarian cryopreservation was the woman's wish, after extensive counselling. The authors comment that further discussion is required about the ethics of the procedure in these circumstances.

Gynaecology and gynaecological oncology

Dysmenorrhoea is a troublesome condition for many women. Coping with it is no easier than it used to be in the past and indeed may perhaps be more difficult in the present era of supposed gender equality. This month it is the subject of two papers in the Journal. On page 73 Ortiz reports on the prevalence of the dysmenorrhoea among university students in Mexico. A questionnaire was distributed to 1539 students (mean age 20.4) in six university programs including medicine and psychology. Among the 64% of students who experienced dysmenorrhoea, the condition was mild in 36.1%, moderate in 43.8% and severe in 20.1%. It was more prevalent among nutrition and psychology students than among medical students and was more intense among nursing students than among students of medicine or dentistry. Sixty-five percent of those with dysmenorrhoea reported that it limited their activities and 42% reported absenteeism, but only 26% had consulted a doctor because of the condition.

Treatment of dysmenorrhoea is most commonly by self-medication, the efficacy of which is difficult to assess. A double-blind randomised trial of the treatment of primary dysmenorrhoea is reported on page 86 by Pareek and colleagues from India. This multicentric study enrolled 200 women who were randomly allocated either to a combination of aclofenac and drotaverine or to aclofenac alone for 3 days. Both treatments were effective but the combination therapy was significantly superior to the monotherapy and the authors report that it was well tolerated.

Uterine fibroids (UF) are another common benign condition which makes life difficult for many women. On page 96 Downes and colleagues from Europe and the USA report on the European component of the 2007 National Health and Wellness Survey, a self-administered Internet-based questionnaire written in English and translated into the languages of four other European countries (France, Germany, Italy and Spain). Responses from over 350 women in each of these countries, and the UK, were analysed. The prevalence of a diagnosis of UF ranged from 11.7% to 23.6%, and the prevalence of undiagnosed bleeding symptoms was very similar. Among employed women with a diagnosis of UF, absenteeism was reported by 32.7%. True gender equality is difficult to achieve when nature is not on your side.

Gynaecological urology

The difficult nature of surgery deep in the pelvis is the main reason why gynaecological urology has become a subspecialty in its own right. Abdominal sacrocolpopexy is considered the gold standard for pelvic organ prolapse repair but the presacral space is full of vascular and nervous pathways and the operation carries the risk of injury to vessels and nerves. Life-threatening haemorrhage is reported to occur in 4.4% of these procedures, and postoperative sequelae in the form of bowel, urinary and sexual dysfunctions have been described. To keep these risks to a minimum, accurate anatomical knowledge is required. On page 103 Shiozawa and colleagues from Tübingen, Germany, report a study of cadavers which focuses on the autonomic nervous system, beginning with the superior hypogastric plexus and including the hypogastric and splanchnic nerves. The authors conclude with a practical recommendation for a safe surgical approach. Even in this era of computerized imaging, lessons can still be learned from painstaking work in the dissecting room.

J. Drife