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Editor's highlights

What's new?

Female sexual dysfunction seems to be becoming a subject of controversy. Recently it was described as a "new condition" constructed by pharmaceutical companies trying to create a market for drugs of doubtful effectiveness (BMJ 2010; 341: c5050). An accompanying commentary agreed that doctors often prescribe such medication because they feel their therapeutic options are very limited. The commentary also pointed out, however, that definitions of female sexual dysfunction are being revised and that the best available evidence supports a multidisciplinary or biopsychosocial approach to treatment (BMJ 2010; 314: c5336). Such a complex topic should not be presented as an over-simplified debate. When this happens, patients are unlikely to benefit.

A more helpful approach is presented on page 117 by Jha and Thakar from the UK. Their review begins by summarising how common the problem is, according to surveys in various countries. Critics are indeed questioning recent data on prevalence, but much depends on how "sexual dysfunction" is defined, on women's expectations and perhaps on the expectations of their partners. Misinformation in the media often contributes to patients' confusion, and as sexual mores change with time, the definition of normal sexual behaviour is as elusive as ever. Jha and Thakar discuss how sexual function alters with age and how physical, social and psychological factors interact in the aetiology of dysfunction. The authors then provide an insightful review of investigation and management. Gynaecologists are well aware of how difficult and time-consuming the treatment of sexual dysfunction can be. The days when doctors simply reached for a prescription pad are, we believe, long gone, if they ever existed.

Our second review also concerns attitudes to sex and reproduction. Many people find artificial contraception unacceptable or undesirable but they know that the alternative, "natural family planning", does not enjoy a high reputation for effectiveness. Methods of predicting a woman's fertile period are perhaps more useful to couples who are trying to conceive than to those wishing to avoid pregnancy altogether. On page 124 Genuis and Bouchard from Canada discuss how new technology is refining these methods. Hand-held computerised monitors are now available which measure changes in urinary oestrone-3-glucuronide and luteinising hormone, and there are other devices which incorporate additional data on menstrual length or basal body temperature. The authors discuss the limitations of these methods but conclude that fertility monitoring is now emerging as a promising option for some women who are looking for a safe and effective method of family planning.

Obstetrics and maternal–fetal medicine

Another of the effects of new technology is highlighted on page 156 in a study by Wackerle and colleagues from Zurich, Switzerland. It has become commonplace for women to carry their own maternity notes and, although some obstetricians initially had reservations about this idea, it has proved practical and useful. A Cochrane review of woman-held maternity records concluded that they increase women's satisfaction and improve the availability of notes during hospital attendance. They are, however, also associated, for unknown reasons, with a higher operative delivery rate. In 2005 Zurich Maternity Hospital went a step further and gave antenatal patients their notes on a USB stick. Wackerle and colleagues have compared 200 women who had antenatal care at this hospital and 200 women who attended for delivery only, after antenatal care elsewhere. The women in the "USB group" were happy with their experience and 7.5% of them had shared their stick data with a doctor outside the department. Again though, primary caesarean section was inexplicably more frequent in the USB group.

Although antenatal stillbirth is 6–10 times more common than sudden infant death syndrome, it has a low profile in terms of public awareness. Some women who have experienced a stillbirth have commented on how shocked they were, because they thought stillbirths no longer occur in this day and age. Researchers have described many different causes and associations, but up to 50% of cases remain unexplained. A problem for research on this topic is a general feeling that little can be done to anticipate and prevent unexplained fetal death in utero. A challenge to this view comes from Simchena and colleagues from Tel Aviv, who performed a prospective study of 67 women who had a stillbirth (page 160). "Placental stillbirth", defined as death of a normally formed fetus with clinical and/or histological evidence of a placental contribution to the death, was evident in 33 of the cases. These women were more likely to be nulliparous and to have thrombophilia, and their stillbirths tended to occur earlier in pregnancy. The authors hope that highlighting such risk factors will help in the development of preventive strategies. These are badly needed.

Despite the need to elucidate the causes of stillbirth, rates of perinatal post-mortem examination have fallen in recent years in many countries. This has been blamed on specific events such as publicity given to the retention of organs without parental consent, but the underlying reasons are more complex. The public has begun to believe that medical science longer needs such "old-fashioned" methods as autopsy, and doctors have become

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reluctant to explain to grieving parents why it is worthwhile. On page 148 Stock and colleagues from Edinburgh, UK, describe a retrospective study of autopsy rates in their hospital from 1991 to 2008. In the mid-1990s the rate fell after adverse national publicity, but since then there has been a steady rise, with the rate in their hospital being consistently higher than those reported elsewhere. The authors attribute this to new guidelines stipulating that mothers should be counseled by senior staff, and to the fact that the perinatal pathology department moved to the same site as the maternity hospital. This led to closer liaison between pathologists and clinical staff, which in turn meant that doctors and midwives were better able to support parents who agreed to autopsy.

Reproductive medicine and endocrinology

Anorexia nervosa is a serious condition that may have a fatal outcome. Because it causes oligomenorrhoea or amenorrhoea, its first presentation may be to a gynaecologist. It is therefore important for gynaecologists to understand the link between eating disorders and menstrual problems, so that patients can be appropriately diagnosed and referred. Unfortunately, however, knowledge appears to be patchy. On page 170 Michala and Antsaklis report the responses of 94 gynaecologists in Athens to a brief anonymous questionnaire. Their study showed that 10% of respondents never weigh patients during evaluation of amenorrhoea, that over 40% would prescribe hormone replacement to women with anorexia nervosa and that 72% felt their knowledge of anorexia nervosa was inadequate. Emerging evidence shows that hormone replacement is of no benefit in these cases, and the authors conclude that more education among gynaecologists is required so that patients can be identified in the early stages of the disease.

The levonorgestrel-releasing intrauterine system (LNG IUS) is a form of hormone therapy with well-documented benefits. Before the menopause it can provide contraception and control of menorrhagia, and afterwards it can provide endometrial protection for women receiving oestrogen replacement therapy (ERT). Its use in each of these groups has been well studied, but on page 176 Depypere and colleagues present for the first time a study of the LNG IUS during the menopausal transition, as one set of indications merges into another. Their multicentre study, conducted in four European countries, recruited 394 healthy women aged 45–51, of whom 168 eventually became eligible for postmenopausal ERT. Patterns of vaginal bleeding were recorded over a five-year period and there was no significant difference between the end of the contraceptive phase and the beginning of the ERT phase. The authors conclude that continuing use of the LNG IUS during this transition has no adverse effects and that its combination with ERT has a positive effect on women's quality of life.

Gynaecology and gynaecological oncology

Training new surgeons is essential for the future of the specialty but if we require surgery ourselves, most of us would prefer to be operated on by a surgeon at the height of his or her powers. A study of patients' attitudes towards the participation of trainees, or "residents", during surgery is presented on page 203 by Versluis and colleagues from The Netherlands. The authors handed out questionnaires to 247 women planned for gynaecological surgery between July 2007 and February 2008. They found that patients were confident in a senior resident considered competent and under the supervision of a specialist, but less confident in less experienced residents and in those operating unsupervised. These results are perhaps not surprising, but the study also revealed that patients lack an understanding of surgical training and of the terminology used to describe the surgical hierarchy. Many patients, for example, believed that a resident is less educated than a medical student. The authors recommend that patient education should be improved and that more evidence on the effect of resident participation on outcome is needed to help us assure patients that their confidence is justified.

Borderline ovarian tumours, as their name implies, generally have an excellent prognosis but still entail some risk. On page 188 Benito and colleagues from Las Palmas de Gran Canaria, Spain, report a retrospective study of 163 patients with such tumours seen at their hospital between 1990 and 2005. Overall the recurrence rate was 7.9% and the mortality rate was 4.9%. Serous tumours were found in 68 cases and mucinous tumours in 91 cases. Although serous tumours presented with more unfavourable anatomopathological characteristics, they were associated with a significantly higher overall survival rate than mucinous tumours. The authors conclude that there are clear clinical differences between these tumours, and they advise physicians to be aware that the aggressive potential of mucinous borderline ovarian tumours is not negligible.

Gynaecological urology

The levator ani muscle is the subject of two papers in this issue, both from Sydney, Australia. Vaginal delivery can cause avulsion of the levator ani from the inferior pubic ramus, and studies using magnetic resonance and transperineal ultrasound have found avulsion injury in 15–35% of vaginally parous women. It might be expected that such defects in the levator would be related to stress urinary incontinence but the evidence on this is far from clear. On page 215 Shek and colleagues describe a study of 198 women with prolapse symptoms who had undergone urodynamic testing and 4D transperineal ultrasound. Levator avulsion was found in 35 of the women but was not significantly associated with urethral mobility. The relationship between avulsion and prolapse, however, is clearer. On page 220 Model and colleagues describe a study of 737 patients referred to the same tertiary unit with symptoms of pelvic floor dysfunction. Of these, 248 patients had previously undergone hysterectomy and another 314 had undergone anti-incontinence or prolapse surgery. In all groups, avulsion injury of the puborectalis muscle was significantly associated with prolapse. The authors recommend prospective studies to evaluate the influence of levator trauma on the effectiveness of modern prolapse procedures using mesh implants.

J. Drife