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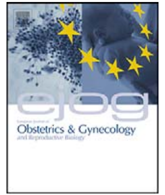

Editor's highlights

What's new?

In our last issue (December 2010) we published a review of the investigation and management of sexual dysfunction, and we mentioned that patients' confusion about sex often arises from media misinformation. This month, our first review (page 3) develops this theme with regard to the female orgasm. The author, Vincenzo Puppo of Bologna, Italy, begins with a quote from a 2009 EJOGRB paper: "sexual health is a global issue that is vital to overall well-being" and includes a quote from a 1948 textbook: "Exalting vaginal orgasm while decrying clitoris satisfaction is found to beget much frustration. Orgasm is orgasm, however achieved". In the interval between these statements a myth developed that in the vagina there is an anatomical focus of sexual pleasure, the "G-spot.". It was named after its supposed discoverer, Ernst Grafenberg, better known in our specialty for developing a successful intrauterine device.

Puppo begins by discussing the anatomy and embryology of the vulva and vagina. He describes how the tale of the "G-spot" developed, and points out that it was not mentioned in Grafenberg's 1950 paper on the role of the urethra in female orgasm. The relevance of this story is not merely historical. Some patients are vulnerable to the idea that they are missing out sexually, and unfortunately some medical practitioners take advantage of this by offering procedures such as "vaginal rejuvenation" or "G-spot amplification". The American College of Obstetricians and Gynecologists has had to issue a veiled warning about these practices. Myth-making has occurred throughout history but when it happens in medicine the result can be harm to patients. Puppo's review is a useful corrective.

Our second review (page 9) is based on a survey of current practice with regard to pain relief during outpatient hysteroscopy (OPH), a procedure which is being increasingly used and which can still be a painful experience for some women. O'Flynn and colleagues from Manchester sent a questionnaire to 250 gynaecologists in the UK and received responses from 115, of whom 88 offered OPH. Among these, about one-third offered routine premedication with either oral analgesia or local anaesthesia. The remainder did not. There was no consensus about the type of pain relief: some gynaecologists offered oral analgesia only, some local anaesthesia only, and some (41%) offered a combination of the two. The authors review the options available, including paracervical block and intrauterine anaesthesia, and they call for more high-powered, randomised placebo-controlled trials to assess the optimum route of pain relief and the most appropriate dose.

Obstetrics and maternal-fetal medicine

Obesity is now a major health problem in some countries such as the USA and the UK. It is also associated with a significant increase in the caesarean section (CS) rate. CS in an obese woman can be technically challenging and carries an increased risk of complications, some of which may be reduced by appropriate precautions such as routine thromboprophylaxis. Obtaining adequate surgical exposure can be difficult. It has been suggested that for obese gynaecological patients a vertical skin incision (VSI) should be used but there are concerns about this approach for CS, including an increased risk of wound dehiscence and the possibility that a VSI may increase the chance of a vertical uterine incision, with consequent risks in future pregnancies. Bell and colleagues from the USA investigated these concerns. On page 16 they report a retrospective cohort study of 424 morbidly obese women (BMI > 35) undergoing CS between June 2004 and December 2006 in a single institution. After adjusting for confounders they found that women with a VSI did not have an increase in perioperative morbidity but were more likely to have a vertical uterine incision. The authors recommend that given the potential impact of a classical uterine scar, obstetricians and patients should discuss the long-term morbidity and the need for repeat CS in future pregnancies.

Preterm delivery carries a risk of recurrence. Women with a history of preterm birth are therefore a high-risk group who need special attention. Low socioeconomic status is another risk factor for recurrence, but one which cannot easily be changed. On page 40 Ratzon and colleagues from Beer Sheva, Israel, report a study of risk factors for recurrent preterm delivery among Bedouin women, who have high fertility rates, a traditional lifestyle and low socioeconomic status but with access to modern healthcare. From a population of 13,611 women who had two consecutive singleton births in a single centre between 1988 and 2007, the authors identified 1470 who had a preterm delivery in their first birth and 362 who had a recurrent preterm delivery in their second birth. Factors associated with recurrence included young maternal age and short inter-pregnancy interval. Multivariate analysis showed that lack of prenatal care was associated with a fourfold increase in adverse pregnancy outcomes. The authors conclude that even if recurrence cannot be prevented, it is important that quality prenatal care is accessible to women who have had previous preterm delivery.

The effect of depression on neonatal outcome was studied by Bodecs and colleagues from Hungary (page 45) through a monitoring system which registered every pregnant woman in a single town for a period of 1 year. By means of questionnaires, 307 women were assessed for depression, anxiety and self-esteem

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in early pregnancy, and at the end of the follow-up period data on 261 mothers and their singleton neonates were available. Depression and anxiety were not associated with neonatal outcomes, while higher maternal self-esteem was associated with higher birth weight in boys, and higher socio-economic status was associated with higher birth weight in girls. Women with depression may worry that the depression itself is harming their baby and it is helpful to be able to reassure them about this.

Reproductive medicine and endocrinology

Assisted reproductive treatment (ART) is associated with an increased risk of adverse perinatal outcomes. Part of the reason is that it is associated with older women and with a higher than normal proportion of multiple pregnancies. Singleton births after ART, however, still seem to carry a higher risk of preterm birth, and some small studies have suggested an increased risk in IVF compared to ICSI pregnancies. On page 62 Nils-Halvdan Morken of Bergen reports a national population-based study using Norwegian Medical Birth Register data. Between 1990 and 2006 there were 5824 pregnancies after IVF and ICSI, and multinomial regression analysis indicates that IVF pregnancies had a 60% increased risk of iatrogenic moderately preterm delivery compared to ICSI pregnancies. The reason is unclear, but the author suggests that it may be due more to maternal constitutional factors than to the method of conception.

Gynaecology and gynaecological oncology

The levonorgestrel-releasing intrauterine system (LNG-IUS) has been available in some European countries for twenty years and in the US for ten years. It is known to be an effective alternative to hysterectomy for menorrhagia, although there is little evidence that it has reduced hysterectomy rates. In recent years the main change in the pattern of hysterectomy for benign disease has been a move away from abdominal hysterectomy, not a reduction in the overall number of operations. The LNG-IUS is used mainly by women who wish to retain their uterus, and in this issue we have two papers about its use in Spain. In the first (page 67) Lete and colleagues from Vitoria-Gasteiz report a retrospective study of 216 women who had a LNG-IUS inserted for heavy menstrual bleeding between 2000 and 2003. Of these women, 60% used the device for five years and, excluding those who reached the menopause, almost 90% of the users chose to have a second device inserted, demonstrating its acceptability. The second paper (page 71) is a detailed economic analysis, using a Markov model, comparing the cost-effectiveness of the LNG-IUS to combined oral contraception or progestogens in the first-line treatment of dysfunctional uterine bleeding. The authors conclude that the LNG-IUS is less costly and more effective than the other options and provides the greatest health-related quality of life.

Surgical training is a topic that was addressed in our last issue by authors from The Netherlands who carried out a questionnaire study of patients' attitudes. This month a different team of authors from that country present a study of the expectations of surgeons. van der Houwen and colleagues interviewed three focus groups of gynaecology consultants, representing over half of the training hospitals in The Netherlands, and four focus groups of trainees from university and non-university hospitals. The resulting paper is a fascinating analysis of the complexity of trainer–trainee interaction when both are aware that the highest priority is the safety of the patient. The key to success, say the authors, is to structure the teaching and learning process by talking about it before, during and after the procedure.

Gynaecological urology

Surgical treatment of prolapse may unmask urethral incompetence and leave the patient with urinary incontinence that was not present before the operation. The International Continence Society therefore recommends pre-operative urodynamic investigation in patients with advanced pelvic organ prolapse. Such investigation is not easy, however, and on page 105 Karateke and colleagues from Istanbul, Turkey, report a technique of placing ring forceps on the anterolateral sulcuses bilaterally to reduce the prolapse before urodynamic testing, mimicking the effects of surgery. The authors evaluated 79 patients and diagnosed occult stress urinary incontinence in 25, who had trans-obturator tape (TOT) inserted at the time of the operative procedure. The incidence of post-operative incontinence was similar in the TOT and non-TOT groups. The authors comment that prospective randomised studies are now necessary.

The incidence of vulvar cancer is rising and in an increasing number of cases it is located close to the urethral opening, so that surgical treatment carries the risk of causing urinary incontinence. On page 108 Hampl and colleagues from Duesseldorf, Germany, describe a series of 19 patients between 2002 and 2007 whose treatment involved partial urethral resection of up to 1.5 cm. Five complained afterwards of urinary disturbances. All but one, however, were continent by urodynamic criteria, and in the remaining case the measurement was unreliable. The authors conclude that the risk of urinary stress incontinence after partial urethral dissection in anterior vulvar carcinoma is modest, justifying this kind of operation as a safe treatment.

Letter to the editor—brief communications

Once again we recommend readers to take note of the clinical lessons in the case reports at the back of this issue. These include a case from Murcia, Spain, of a large vulval haematoma associated with superficial lacerations caused by consensual sexual activity. An interventional radiologist was consulted and embolisation of a superficial branch of the internal pudendal artery stopped the bleeding. The authors comment that this is one of the few reports of embolisation of a non-puerperal vulval haematoma.

J. Drife