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Editor's highlights

This month, as spring approaches, professional meetings resume. In Spain, the World Congress on Women's Mental Health and the European Congress on Osteoporosis and Osteoarthritis take place in Madrid and Valencia respectively. In the USA the Society for Gynecologic Investigation meets in Miami, Florida. In the UK the Confidential Enquiry into Maternal Deaths launches its latest report, *Saving Mothers' Lives 2006–2008*, with meetings on consecutive days in three British cities and, for the first time, in Dublin. From now on the Republic of Ireland will be part of the Enquiry, which already covers England, Wales, Scotland and Northern Ireland. The Irish Republic, with a population of about 4.5 million, cannot conduct a truly "confidential" enquiry on its small number of maternal deaths. Similar international co-operation should be considered by other small countries, and perhaps by larger ones.

There is good news in the latest UK report. At last there is a fall in deaths from pulmonary embolism, which for over 20 years had been the country's leading cause of Direct maternal deaths. This follows the publication of thromboprophylaxis guidelines, which the Enquiry called for in previous reports. Another welcome trend is a fall in deaths among Black African mothers, whose at-risk status has been repeatedly highlighted by the Enquiry. These reductions demonstrate that lives can be saved by well-focussed maternity care.

The UK's overall maternal death rate has declined slightly, despite rising rates of obesity and increasing numbers of births, particularly to women born overseas. In the USA, by contrast, maternal mortality appears to have risen dramatically in the last 20 years (accurate data are lacking in some areas). In all countries, including the USA, mortality rates are highest among poorer women and ethnic minorities. It has been hard for European doctors to understand the resistance among some of our US colleagues to President Obama's legislation aimed at reducing health differentials and making pregnancy safer for American women at highest risk.

What's new?

Pain relief is an essential part of any invasive procedure, and as more gynaecological work has moved from the operating theatre to the outpatient clinic or office, ensuring adequate analgesia has become the gynaecologist's responsibility rather than the anaesthetist's. The evidence base has not kept pace with this change in practice, however. Two months ago we published a survey which showed wide variation in UK practice regarding the use of oral analgesics or local anaesthetics during outpatient hysteroscopy. It reviewed the available methods of analgesia and highlighted the lack of national guidelines. This month (page 3), Ahmad and other members of the same team from Manchester, UK, extend their work with a systematic review and meta-analysis of pain relief for a range of gynaecological outpatient procedures. The authors report beneficial effects from local anaesthetics for hysteroscopy and hysterosalpingo-contrastsonography, and they recommend consideration of local anaesthetics to reduce the failure rate of hysteroscopy in postmenopausal women.

Obstetrics and maternal–fetal medicine

Birth under water was popularized almost 30 years ago and today most maternity hospitals in the UK have birthing pools, though only a small number of babies are delivered in water. Concerns over safety were answered by studies showing no increase in perinatal mortality or morbidity. In 2009 a Cochrane review concluded that waterbirth reduced the need for analgesia in labour but evidence on other outcomes was lacking. The importance of pelvic floor injury as a birth outcome is now recognized, and a limited number of studies have shown a non-significant trend to a higher risk of third degree tears after waterbirth. On page 27 Cortes and colleagues present a retrospective analysis of the incidence of perineal trauma among nulliparous women in St Thomas's Hospital, London, comparing 160 waterbirths with 623 women who had a conventional delivery without any medical intervention. The length of the second stage of labour was significantly shorter in the waterbirth group (mean 43 min versus 57 min) and the incidence of third degree tears was doubled (2.5% versus 1.2%). One year after delivery a questionnaire survey showed a high degree of satisfaction with waterbirth and no difference in urinary symptoms between the groups. We note, however, that the incidence of *de novo* stress incontinence in both groups was 66–68%.

Inflammation is a major risk factor for pre-term labour, with chorioamnionitis being detected in up to 60% of cases. Two papers this month are about inflammatory markers. On page 31 Wirbelaur and colleagues from Wuerzburg, Germany, report a prospective study of 15 infants born at 32 weeks' gestation or earlier. In five of them, funisitis was detected by histological examination. Investigation of cytokine gene expression in umbilical cord blood mononuclear cells showed that the expression of interleukin-10 was significantly higher in the funisitis group compared to the others. The authors hypothesise that intrauterine activation of this

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anti-inflammatory cytokine may adversely affect postnatal immune reactions. On page 14 Brik and colleagues from Valencia, Spain, present a study of another interleukin, IL-6, as a predictor of preterm delivery. A series of 100 women with threatened preterm labour underwent transvaginal ultrasound scanning to assess cervical length and had a cervical swab taken for IL-6 detection. The authors report that cervical IL-6 can predict preterm delivery similarly to cervical length, and a combination of both tests achieves better accuracy than either test alone.

Reproductive medicine and endocrinology

For years doctors have been warning patients about the dangers of smoking and patients have now come to expect this advice from us. Vedmedovska and colleagues from Latvia and Belgium, reporting on pathological changes in the placenta (page 36), emphasise the need to persuade women to give up smoking before they become pregnant. This is specially important for patients with infertility, as smoking is associated with a poorer prognosis in assisted reproductive techniques. Nevertheless, doctors themselves do not always follow the advice they give their patients. On page 44 Freour and colleagues from Nantes, France, report a postal survey of 803 French physicians specializing in infertility. Doctors were asked about their own smoking habits and their attitudes towards patients' smoking. The response rate was 42% and of the responders, 13% were current smokers. More than 80% of responders always asked patients about smoking status and cannabis consumption, most advised them to quit, and 24% refused treatment to patients who continued to smoke. Interestingly, results were unaffected by the doctor's own smoking status. The authors point out that their study had a relatively low response rate but even so they found heterogeneity of management depending on the specialist's age, gender and occupation, which underlines the need for better professional information to reduce smoking among infertile patients.

Unexplained primary infertility may be associated with septate uterus, which accounts for 80–90% of all major malformations of the female reproductive tract. The role of septoplasty in infertile patients remains controversial, however, and there is a lack of good randomized, controlled data. Shokeir and colleagues from Mansoura, Egypt (page 54) carried out a prospective study of 103 infertile women with uterine septum as a sole cause for reproductive failure. All patients underwent hysteroscopic septoplasy, and complete follow-up data were available on 88 of the women. Forty-two became pregnant, of whom nearly 80% conceived spontaneously, and 36 liveborn babies were delivered. The pregnancy rate was higher in younger women, in those with less than 3 years' infertility and in those with a septum size larger than one half of the uterine length. The authors conclude that it is time for a large prospective multicentre study comparing this treatment with observation only.

Gynaecology and gynaecological oncology

Gonadotrophins have been linked to the development of ovarian cancer. For example, combined oral contraceptives, which suppress gonadotrophin production, have a strong and long-lasting protective effect against the disease. In attempts to elucidate these links, most attention has focused, not surprisingly, on follicle-stimulating hormone. The relatively few studies of luteinising hormone (LH) and have produced inconsistent results. On page 69 Zhang and colleagues from Shanghai, China, discuss the possibility that the raised LH levels in postmenopausal women may affect the effectiveness of chemotherapy for ovarian cancer. There is evidence that LH can affect the expression of survivin, an inhibitor of apoptosis and promoter of tumour proliferation which is overexpressed in various tumour types including ovarian cancer. The authors performed an in vitro study of survivin expression in an ovarian cancer cell line and found that LH administration induced survivin expression in a dose-dependent manner. LH also blocked apoptosis induced by cisplatin. The authors suggest that an ability to target survivin would enhance the efficacy of chemotherapy for ovarian cancer.

Uterine fibroids are found in 25% of women. On page 79 Liu and colleagues, also from Shanghai, report a prospective randomized controlled trial of two methods of treating these common tumours. They randomized 332 women with symptomatic fibroids either to laparoscopic uterine artery occlusion plus myomectomy (LAUO + M) or to classic intrafascial supracervical hysterectomy. Quality of life was assessed by questionnaires before surgery and at 2 and 24 months afterwards. The LAUO + M group's scores were significantly better at 2 months and at 24 months, and the rate of fibroid recurrence in this group was low, at only 2.5%. The authors caution that long-term follow-up is necessary before any definitive statement can be made about the role of LAUO + M in comparison with other therapies.

Gynaecological urology

The two papers in this section address aspects of the surgical treatment of genital prolapse. One focuses on pre-operative assessment. Prolapse may mask urinary incontinence, and various tests are used to predict the effects of surgery by simulating the postoperative position of the uterus – for example, by using a preoperative pessary. On page 110 Liapis and colleagues from Athens report on 82 patients with a positive pessary test and severe genital prolapse. Patients were allocated alternately to prolapse surgery only or to prolapse surgery plus insertion of transobturator tension-free vaginal tape (TVT-O). At 2-year follow up, the objective cure rates for urinary incontinence were 88% in the TVT-O group and 59% in the other group. The authors recommend the pessary test for the prediction of occult stress incontinence, and consider the TVT-O procedure as safe and effective in this context.

The other paper focuses on surgical failure. Chen and colleagues from Taichung, Taiwan (page 106) performed posterior intravaginal slingplasty for uterine or vaginal vault prolapse on 65 consecutive patients. Four were lost to follow-up and the rest were assessed regularly until 30 months after operation. The surgical failure rate was 13% and the risk of failure was 10 times greater in women with stage IV prolapse than stage II prolapse. The authors conclude that they will consider posterior IVS for the treatment of symptomatic moderate prolapse but would hesitate to use this procedure for procidentia.

Additionally, a letter from Istanbul, Turkey (page 114) reports a complication of transobturator tape (TOT). Karateke and colleagues describe a patient complaining of overactive bladder due to urethral obstruction after insertion of TOT for stress incontinence 12 months previously. Cutting the tape on both sides of the urethra under local anaesthesia restored normal urinary function.

J. Drife