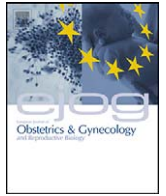




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Editor's highlights

We were saddened, as this issue of the Journal was being prepared, to hear of the death of our distinguished Editor Emeritus, Professor TKAB Eskes, on 28th March 2011. Tom Eskes was for many years one of the leaders of our specialty in Europe and his influence on this journal was immense, right from the start. He was present at the meetings which led to the foundation of the *European Journal of Obstetrics & Gynecology and Reproductive Biology* in 1971. He became the Journal's Chief Editor in 1977 and remained in this post for 24 years. In 2001 his successor as Editor-in-Chief, Professor Jim Thornton, described him in these pages as a "renaissance man" – a fitting term for such a prolific researcher who also helped set up both EBCOG and EAGO and who opened the 1992 European Congress of Perinatal Medicine in Amsterdam by playing the piano during his plenary lecture. We owe an immense debt to Tom and our thoughts are with his wife and family at this time. A full obituary will appear in a future issue.

What's new?

Vaginal pessaries are among the few medical treatments that were used in ancient times and are still valuable today. The longer a treatment has existed, however, the less likely it is to have been studied by controlled trials. The use of pessaries in the treatment of pelvic organ prolapse is the subject of our first review (page 125). Oliver and colleagues from Croydon, UK, point out that as female life expectancy rises, the incidence of prolapse will increase, making it more important to have a sound evidence base for the use of pessary treatment. They performed a Medline search covering a 45-year period, and report that most studies showed moderate success in the short term management of prolapse and almost complete remission of prolapse-related symptoms. These results, however, were mainly from retrospective or cohort studies and the authors conclude that controlled trials are necessary to assess long-term efficacy.

Urinary tract infection (UTI) is another common problem in women. In our second review, on page 131, Salvatore and colleagues from Italy point out that at least one in three women will experience one or more episodes of UTI in her lifetime. The authors conducted a comprehensive review of experimental and clinical studies in order to draw up an evidence-based clinical guideline on the management of UTI. The result is a wide-ranging review covering risk factors, diagnosis and treatment, and including groups at high risk such as children, diabetics and patients with spinal cord injury, as well as the treatment of pregnant and breast-feeding women. For many readers the article will shed new light on urinary infections, such as the

information that a Cochrane review found that cranberries are effective in preventing recurrent UTI, especially in sexually active young women. The article concludes by mentioning immunoactive prophylaxis with a multivalent bacterial vaccine.

Expert opinion

Intrapartum fetal blood sampling (FBS), introduced in the 1960s at the same time as cardiotocography, has been a standard technique throughout the working lifetime of all obstetricians currently in practice. As mentioned above, the longer a technique has existed the less likely it is to have been rigorously evaluated, and on page 137 Mahendru and Lees from Cambridge, UK, point out that the claim of FBS to be regarded as the "gold standard" diagnostic technique for assessing the fetal condition in labour has never been validated in humans. The authors discuss the practical difficulties involved in obtaining a good blood sample and the multiple sources of error whose impact on the results has been "poorly, if at all defined". Clearly FBS has not succeeded in keeping down the caesarean section rate, as originally hoped. Mahendru and Lees conclude that it cannot be considered as a "gold standard" test for fetal hypoxia/acidaemia. They are not alone. In last month's issue we published a report by Doret and colleagues, who stated that FBS had not been performed in their department – a tertiary centre in France – for many years.

Obstetrics and maternal–fetal medicine

Cardiotocographic (CTG) abnormalities during induction of labour are worrying because there are few other options for checking the fetal condition while the cervix is still closed. On page 144 Pevzner and colleagues from the US and the UK report a secondary analysis from a multicentre randomized trial comparing dinoprostone with two doses of misoprostol for the induction of labour. A total of 1308 women were included. During induction, uterine contractile abnormalities were noted in 17% of the dinoprostone and higher-dose misoprostol groups but in only 7% with a lower dose of misoprostol. There were, however, no significant differences in the rates of CTG abnormalities during induction. These occurred in around 10% of each group, though they appeared later in the low-dose misoprostol group, which took the longest time to deliver. Very few women required caesarean section (CS) for CTG abnormalities during induction, but it seems that induction may indeed represent the start of a "cascade of intervention" as the overall CS rates were 26–28% in all three groups.

The low rate of perinatal autopsies has been the subject of several papers in this Journal, most recently in December 2010, when authors from Edinburgh, UK, discussed the role of the perinatal pathologist in educating staff about their value. Further evidence of the importance of post-mortem examination is presented on page 149 by Joo and colleagues from Budapest. The authors analysed 683 pregnancies terminated because of ultrasound-diagnosed anatomical malformations. The ultrasound diagnosis was confirmed in the authors' tertiary department and autopsy was performed usually within 24 h of abortion. In four of the five organ systems, and for body wall malformations, there was complete agreement between ultrasound and postmortem diagnoses in 70% of cases, but the proportion was only 30% for urinary tract malformations. Overall, the ultrasound diagnosis was completely incorrect in 17% of cases. The authors comment that postmortem examination remains an indispensable quality control.

Babies are still being born with myelomeningocele, despite efforts to promote periconceptual vitamin supplementation and the availability of prenatal diagnosis with the option of termination. Research on managing rather than preventing the condition is reported on page 171 by Fontecha and colleagues from Barcelona, Spain, who created artificial myelomeningoceles in 15 fetal sheep. Six were left untreated and the other nine underwent fetoscopic coverage of the defect using an inert patch, which proved to be successful in averting neurological damage and Chiari malformation. If this technique becomes applicable in humans it will offer practical help to couples who opt to continue a pregnancy after prenatal diagnosis of myelomeningocele. In last month's issue we published a retrospective clinical study of 95 infants with myelomeningocele, showing there is no evidence that CS improves the outcome compared with vaginal delivery, whether as vertex or breech presentation. That report came from Radboud University, Nijmegen, where Professor Eskes worked for many years on the prevention and treatment of neural tube defects. It is good to see this research continuing.

Reproductive medicine and endocrinology

When women with endometriosis undergo IVF, the pregnancy rate is about half that of women with tubal factor infertility. This may be due to abnormalities in their eutopic (intrauterine) endometrium. Mohamed and colleagues from the UK and Egypt (page 177) performed a retrospective study of embryo transfer (ET) IVF cycles in 7286 women, 415 of whom had endometriosis-related infertility. The authors compared live birth rates (LBR) in cycles using fresh and frozen embryos. In the non-endometriosis group, LBR were significantly higher after fresh than frozen ET, but in women with endometriosis the LBR after frozen ET was as high as after fresh ET. The authors hypothesise that in frozen cycles, down-regulation with gonadotrophin-releasing hormone (GnRH) agonist combined with low-level steroid stimulation produces the optimal endometrial environment for implantation. They suggest a strategy of freezing all embryos in cases of endometriosis – a hypothesis that would have to be tested by a large randomized controlled trial.

Down-regulation in IVF is also the subject of a report on page 186 by Yoldemir and colleagues from Istanbul, Turkey. The authors studied 162 women undergoing down-regulation with GnRH

agonist followed by controlled ovarian stimulation (COS) with recombinant FSH, and they assessed the ovarian response by transvaginal ultrasound. Women who had a dominant follicle on day 5 of COS were compared with those who did not. Clinical pregnancy rates were higher in the latter group. The authors conclude that synchronous growth of follicles during COS seems to determine better implantation, but that larger studies are needed.

Gynaecology and gynaecological oncology

Caesarean scar pregnancy (CSP) is a dangerous form of ectopic pregnancy which is rare but has become more common as CS rates have risen. On page 209 Jiang and colleagues from Shenyang, China, report 45 cases of CSP treated with a single dose of intramuscular methotrexate, plus local methotrexate if gestational cardiac activity was seen. Seven days later, suction curettage was performed under ultrasound control, and a Foley catheter balloon was placed in the cervix to provide tamponade. This regimen was successful in 42 cases, with the other three patients requiring emergency uterine artery embolisation. In the past CSP carried a high risk of uncontrollable bleeding requiring hysterectomy, so these figures are impressive, though the authors call for their results to be confirmed by further research.

Poland has the highest rate of cervical cancer in the northern European countries. In Finland, by contrast, rates are much lower, mainly due to the introduction of a nationwide screening programme almost 50 years ago. Kuczkowska and colleagues from Warsaw (page 212) compared Polish and Finnish students to investigate possible differences in knowledge about cervical cancer which could affect the success of the new screening programmes in Poland. A 20-item questionnaire was answered by 252 Finns and 175 Poles. In both countries the best scores were achieved, not surprisingly, by medical students. In some areas Finns performed better than Poles but the overall knowledge levels in both countries were not high. The authors conclude that a high knowledge level is not essential for a successful screening programme, and that what is needed is that women trust clinicians enough to follow their recommendations.

Gynaecological urology

Laparoscopic sacrocolpopexy (LSC) is a new technique for the treatment of pelvic organ prolapse – certainly by comparison with the pessaries discussed at the start of this issue. On page 217 Sergent and colleagues from France report a series of 119 patients treated with LSC, between October 2003 and March 2009, using an anterior and a posterior polyester mesh. They comment that their study, with all patients followed up for at least one year, is one of the longest series published to date. At a mean follow-up of 34 months, 116 patients were accessible for evaluation. For the apical, anterior and posterior compartments the anatomical success rates were 97%, 89% and 98% respectively, and all functional scores of quality of life and sexual function were improved. The authors comment that the exposure rates with polyester meshes were no higher than with other series using polypropylene meshes but that further studies are warranted to determine long-term outcomes.