

Editor's choice

Cytomegalovirus and fetal damage

Bacterial infections we can usually treat with antibiotics, but producing vaccines against them is difficult because of the complexity of their structure. Viruses, however, are difficult to treat, but at least we have preventive vaccines for many of them, including measles, mumps, rubella, pertussis, polio—and now for some types of human papillomavirus—but cytomegalovirus (CMV) remains a challenge. At least 1 in 200 babies born has been infected with this largest member of the herpesvirus family, which is unique to humans. About 50% of us will have been infected at some time, and some of these primary infections will have been in pregnant women. Luckily, only 10% of infected fetuses become affected, but this still amounts to 1 in 2000 babies born. Attempts are being made to produce a vaccine, but progress has been slow, probably due to the low awareness of the problem among the general public and hence a lack of pressure to provide funding for this research. In this month's issue, we bring you up to date on this important topic. The commentary by editors Amarnath Bhide and Aris Papageorghiou on page 805 summarises current knowledge. On page 823, Benoist *et al.* from Paris, France, present their work studying the markers during pregnancy for a poor neonatal outcome. Both thrombocytopenia and ultrasound abnormalities were significant predictors. They suggest that if there is clear evidence of infection during early pregnancy, measurement of the fetal platelet count by fetal blood sampling may be justified. On page 830, Gindes *et al.* from Israel report their studies of maternal CMV infection in the third trimester. Although 75% of fetuses were infected, none of the 20 babies born alive had symptomatic congenital infection.

Ovarian cancer—is surgery always appropriate?

The treatment of ovarian cancer remains controversial because none of the approaches so far developed has been outstand-

ingly successful, and cure rates remain depressingly low. On page 808, Pomel *et al.* discuss the controversy about debulking surgery. While this has become the accepted norm before chemotherapy, it has been questioned by some, who have suggested that it does not improve the outcome from chemotherapy, which remains the mainstay of treatment. Pomel *et al.* defend their surgical approach and argue for more and better surgical clearances, not fewer. On page 894, Booth *et al.* argue that although the current International Federation of Obstetrics and Gynecology guidelines recommend exploratory laparotomy as the gold standard for all women suspected of having ovarian cancer, not all women will benefit from surgery and they present evidence that those with very advanced disease can be staged without laparotomy by using three Tesla magnetic resonance imaging (standard power is 1.5). The management of these women with and without surgery is currently being investigated by the Medical Research Council UK 'CHORUS' (CHemotherapy OR Upfront Surgery) study. The conclusions of Booth *et al.* are examined in a thoughtful commentary by John Spencer on page 811, an important read for anyone with an interest in this area.

Pain relief in endometriosis

As many as 1 in 10 women suffer from endometriosis, and the condition is present in four of five women with chronic pelvic pain. The multiplicity of treatments available is a testament to the fact that none of them are universally effective, and so, pain relief remains an important palliative goal. A key requirement for the persistence of endometriosis is estrogen, and so, it is logical that aromatase inhibitors (which suppress estrogen production in the peripheral tissues such as fat and decrease circulating estrogen levels considerably) might have a role in palliative care. On page 818, Patwardhan *et al.* report the results of their systematic review, which are that aromatase inhibitors appear to be

promising in alleviating pain, reducing lesion size and improving quality of life, but that data are currently too few for them to be fully confident of this conclusion. Because of the clinical importance of this topic, we commissioned a review of the medical management of endometriosis from Nick Panay on page 814, which sets the findings of Patwardhan *et al.* in context.

Normal values in pregnancy

All obstetricians should be aware that the values of many of the clinical measurements that we make change substantially during normal pregnancy; correct diagnosis therefore requires a knowledge of these changes. A case history of a student I read concerned a woman with mild hypertension who had labour induced because her serum alkaline phosphatase had risen above the normal nonpregnant level. The clinicians managing her care were evidently unaware of the production of alkaline phosphatase from the placenta (used when I was training as a fetoplacental function test!). Conversely, the fall in haemoglobin concentration produced by plasma volume expansion in the middle trimester means that 70% of healthy pregnant women are classified as 'anaemic' by the World Health Organization (WHO) criteria. Even in current practice, I know from personal observation that the substantial falls in ferritin and vitamin B12 levels in normal pregnancy result in many women receiving unnecessary iron and B12 supplementation. We are therefore pleased to publish on page 874, the study by Larsson *et al.* of appropriate reference values for clinical chemistry tests during normal pregnancy. To give just one example, the normal lower limit of ferritin outside pregnancy in their laboratory is 10 micrograms/l, whereas at 28 weeks of pregnancy, it is 3.8 micrograms/l. So, please post this information in a prominent place in your antenatal clinic and there will no longer be any excuse for inappropriate investigation or therapy.

The importance of surgical expertise

How many of you have gazed at a third-degree vaginal tear at 1 a.m. and wondered if you should repair it yourself or whether it would be better to leave it to an expert the following day? Many factors come into play in making that decision; the benefit of a prompt resolution of the problem versus the risk of being blamed as a poor surgeon if subsequently there is anal incontinence. If you do it yourself, there is the prestige of being seen as capable, while deferring it to an expert risks making others think that you are shirking your responsibility merely to get an extra 40 minutes in bed. On page 857, Nordenstam *et al.* report the results of their randomised controlled trial of immediate repair by the attending obstetrician versus delayed repair by an expert team. Unluckily, for the indecisive among us, the results were equally good either way. So, we still need to make an individual decision as to whether we see ourselves as properly trained surgeons who can do the repair well or whether due to lack of expertise we should be deferring to an expert.

Should we publish protocols?

Some years ago, the editorial team decided to encourage the exposure of research trial protocols to peer review by publishing them, so that feedback could be used to improve them. This month, we publish just such a protocol (Oppegaard *et al.*, page 917). However, this policy has to some extent been overtaken by events. International clinical trials registry platforms have proliferated over the past 5 years, including, for example those run by the WHO (www.who.int/ictrp/en/), the US National Institutes of Health (www.clinicaltrials.gov/) and the ISRCTN (International Standardised Randomised Controlled Trial Number) organisation (<http://isrctn.org/>). Take the current protocol as an example. Typing 'cervical ripening before hysteroscopy—randomised controlled clinical trial' into Google produced as the first hit the immediately preceding trial by this group at

www.druglib.com/trial/89/NCT00363389.html, leading on to the current trial at <http://clinicaltrials.gov/ct2/show/NCT00572819?term=2007-004083-52&rank=1>. With such information so readily available, the question has to be asked, what is the added benefit of publishing the abstract in a printed journal, with the rest of the details on yet another website? We will be re-evaluating our policy over the next few months and would welcome readers' comments on this topic.

What makes a Journal?

Academic publishing, like so many other aspects of life, is being revolutionised by the Internet. We used to get our updates by reading journals, newspapers, handouts from pressure groups and pharmaceutical companies, and talking to colleagues. These days, many of us are also likely to get it by 'googling'. There is a mass of information available free online, from journal articles with open access, through institutional repositories and publicly funded resources, such as the WHO, the US National Institutes of Health, the 'On-line Inheritance in Man' website (OMIM), the UK National Library for Health and many more. So, why do we still need journals that have to be paid for? Do they have a special function? A major problem with googling is the sheer amount of information that it throws up. Searching on 'group B streptococcus' in Google produced 287 000 items in 0.42 of a second, and even in PubMed, it was 5806. And that is assuming that you know what you are looking for. Searching on 'keeping up to date in medicine' produced over a million items.

Medical journals perform at least three essential functions. The first is selection, choosing the best articles to put in front of the reader. The second is validation. Peer review is essential for both these functions. Like democracy, it is deeply flawed, but better than the alternatives. It helps us weed out the inconsequential, the unscientific and the frankly fraudulent. Our peer reviewers are 'an army of unsung heroes labouring in the

cause of truth'. A full list of reviewers that contributed in 2007 can be found on page 930. The third function is improvement of the manuscript and that is where our editors come to the fore. They work hard to draw together the opinions of the two or more referees, and other editors (at least two or three per submission, and often five or six), and work with the authors to rectify any identified problems in their paper. Improving the standard of presentation is a vital editorial function; you may think that some of our papers are heavy going, but you should see some of them before they are edited! All of this activity has a cost, and despite the fact that our editors are remunerated at a fraction of their commercial value, the rest of the infrastructure, including the electronic manuscript management system and printing the paper journal also has to be paid for. If these functions were not carried out by medical journals, we would be submerged with a mass of undigested data. The electronic revolution is changing the way in which journal activities are undertaken, but they will remain necessary. All of this brings me to the editor's profiles that are now being published at the end of each month's print journal. The first profiles appeared in May, and we will be publishing four each month, highlighting the breadth of expertise in our editorial team. We have experts covering specialties such as reproductive medicine, oncology, urogynaecology, maternal fetal medicine, basic science, and generic areas, such as ultrasound, systematic reviews and epidemiology. We hope you find the profiles both interesting and impressive. If you want to know what the editor who dealt with your paper looks like and what they do when they are not editing your paper, by the end of this year you will be able to find all of their pictures and mini-biographies online! ■

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