Editorial

This issue of Facts, Views and Vision in Ob/Gyn continues to provide broad input from the fields of Reproductive Medicine, Obstetrics and General Gynaecology. As in previous issues, there is a very welcome interest in a global perspective on our specialty. The Editor-in-Chief and his team are proud of the high-quality papers in the Journal, and we urge our readers to submit their best material.

Belgium now has several MIC units, with MIC standing for maternal intensive care. Confusingly, the same acronym is also being used for medical - as opposed to the surgical - intensive care. In this issue, Van Parys *et al*. performed a much needed systematic review on the topic, and point out that there is confusion about the appropriateness of the term. The authors propose that maternal intermediate care is probably a better caption of the current Belgian situation. They also conclude that it is unclear which conditions warrant referral to an MIC unit.

Semantics aside, the pregnant or postpartum woman and her baby(babies) constitute the primordial "unit" from which any policy should be derived. Given that meta-analyses support intra-uterine transport for an optimal outcome of very preterm newborns, gestational age and fetal condition are paramount. Guidelines should emphasize responsible, dedicated care at both non-MIC and MIC obstetrical centres; all MIC units must be complemented by truly "intensive" care units and specialists. The value of regular, case-based, person-to-person communication between health workers involved in the past, current and future maternal or neonatal care cannot be overestimated. The current labyrinth of scribbled and electronic medical and midwifery notes and printed data pertaining to most referred MIC patients must be streamlined into a single, lucid document. We also need to maintain a flexible health care system with a minimum of referral delays and refusals; of course, both maternal and neonatal referrals are two-way processes. Finally, the nature and possible risks of the condition and the management plan must be discussed with the patient and her significant persons at all times. Experience from other countries shows that detailed "factual" guidelines may actually be detrimental for high-risk obstetrical care if they are accompanied by referral sclerosis and lack of patient empowerment. As always, content and attitude must go hand in hand!

Also in this issue, Dhont presents a mature vision on the issue of hormone treatment for postmenopausal women. The issue is fraught with partisan views, even more so after the publications of the Women's Health Initiative, which are well summarised in the paper. One cannot be blind for the many studies showing that hormone therapy meaningfully affects the incidence of breast cancer. Therefore, recommending hormone therapy to a large population is a bad idea. On the other hand, some oestrogen-deficient brains and bodies appear to be malfunctioning. Well-informed women who feel better on hormone therapy should not be denied this choice and should not be culpabilised. We need much more data on genetic and environmental markers of "oestrogen-hungry" brains. In the end, the discussion will be on those markers, on markers of impending complications of the treatment, and the appropriate proportion of the over-50 population that is better off with hormone therapy. That the answer to the last question should be anywhere below 20% is a major achievement of the WHI.

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