and 95[1]. There were 3010 representative interviews (1454 men and 1546 women) from a population of nearly 1.4 million. It is the biggest published cross sectional survey on this topic that we can find so we are most interested that there are 'much larger randomised trials' (none referenced or on any database) with follow up to old age. Of course, by 95 years of age, 'the obstetric event has to have been one to two decades previously' or perhaps even more!

We have been open and transparent with the data. Although there was a numerical decrease in the prevalence of stress incontinence in women delivered by caesarean section compared with vaginal delivery, this did not reach statistical significance ($\chi^2 = 2.8$, $df = 1$, $P = 0.09$). A non-significant trend in an observational study is not enough to advocate caesarean section for this reason. However, our study showed that the associated prevalence of all major types of pelvic floor dysfunction after caesarean section was 74% of the prevalence after spontaneous vaginal delivery and 67% of the prevalence following an instrumental delivery. As discussed in the paper, these differences were statistically significant, but clinically, many of the same problems of incontinence and prolapse still occur after caesarean section, and it is highly likely that it is pregnancy and its associated hormones *rather than* parturition that is the greatest influence on future pelvic floor function. One of us (PDW) is currently analysing the results of a cohort of nearly 8000 women followed for five years after birth and these data will be available soon. Using the above data to calculate the numbers needed for a prospective randomised controlled trial, we have already advocated that there is justification for a 'term cephalic' trial[2]. We thank Dr Blanchette for nominating us to organise this trial and for his faith in our longevity. In turn, we nominate him to fund it!

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Effectiveness and safety of the oxytocin antagonist atosiban *versus* beta-adrenergic agonists in the treatment of preterm labour

Sir,

We read with great interest the article from the 'Worldwide Atosiban *versus* Beta-agonists Group'[1]. Since the presented results will probably have a great impact on the choice of pharmacologic substance in the treatment of preterm labour, we would like to shed some light on, as we believe, an important finding that has not been further discussed by the authors.

In Table 3, it is shown that among the twin pregnancies in the β-agonist group, 93.3% were still undelivered at 48 hours compared with 75.0% in the atosiban group ($P = 0.003$). The difference remained at seven days (76.7% *vs* 61.4%), albeit not significant. It would be of great interest to have information of the success rate in relation to gestational age at treatment for both the single and twin pregnancies. It may be that atosiban is less effective at earlier gestational ages. The results in favour of the β-agonist group among the twins might therefore be explained by a lower gestational age at treatment in these pregnancies. Myometrial sensitivity to oxytocin increases with gestational age due to an upregulation of the oxytocin receptor, which in fact has been demonstrated towards the end of pregnancy[2]. This relative lack of oxytocin receptors earlier in pregnancy might contribute to a possibly reduced efficacy of atosiban.

Since the increased perinatal morbidity and mortality in twin pregnancy as compared with single pregnancy is mainly due to an increased rate of prematurity, twin pregnancies should be of great concern in this context. We therefore find it important that the relationship between tocolytic efficacy of different agents and type of birth (single/twin) is clarified.

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The tension free vaginal tape procedure is successful in the majority of women with indications for surgical treatment of urinary stress incontinence

Sir,

There have been, over the last two to three years, a spate of articles in various journals about the *tension-free vaginal tape operation*. The authors claim that the tension-free vaginal tape is an effective treatment for all women requiring surgery for genuine stress incontinence and that it may even be effective in women with mixed incontinence[1].

In this paper, two surgeons operated on 161 women and they claimed a 94% cure rate at 16 (7) [mean (SD)] months. The level of expertise of the two surgeons was not mentioned, nor was their success rate with tension-free vaginal tape measured against their success with the tried and tested Burch colposuspension.

Most studies of the tension-free vaginal tape operation are of 13–18 women. By contrast, 344 women were recruited into a multicentre, prospective, randomised trial of colposuspension compared with the tension-free vaginal tape operation for primary genuine stress incontinence in the UK, and the results at six months were presented at the meeting of the International Continence Society in August 2000 in Tampere, Finland[2]. These early results showed that the success of both colposuspension and the tension-free vaginal tape operation varied widely between institutions. No reason for this was stated but it was possibly related to the skill of the surgeons.

There is also a question of consent. Nilsson and Kuuva[1] state that they obtained 'informed consent' but did not elaborate on this. There are few long term results with the tension-free vaginal tape operation, and we wonder whether the women were informed of