"HIGH UTEROSACRAL VAGINAL VAULT SUSPENSION TO REPAIR ENTEROCELE AND APICAL PROLAPSE"
MICKEY KARRAM, MD, AND CHRISTINE VACCARO, DO
(JUNE 2011)

How to identify the uterosacral ligament

The technique described by Dr. Karram and Dr. Vaccaro is excellent—simple and effective. A similar procedure was described by Thomas M. Julian, MD, at the Pelvic Reconstructive and Vaginal Surgery Conference in 2002 in St. Louis, Missouri. He detailed a very helpful maneuver to identify the uterosacral ligament: "With the patient in the high dorsal lithotomy position, an Allis clamp is used to place firm traction on the posterior cul-de-sac on the side where the uterosacral ligament is to be located. The surgeon places a finger in the rectum and draws the finger from a far lateral position until the uterosacral ligament is felt....A second Allis clamp is placed directly on the palpated uterosacral ligament from the transperitoneal side as the ligament is elevated by the underlying rectal finger."[1]

Joseph Capecchi, MD
St. Paul, Minn

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"CAN CERCLAGE PREVENT PRETERM BIRTH IN WOMEN WHO HAVE A SHORT CERVIX?"
JOHN T. REPKE, MD
(EXAMINING THE EVIDENCE; JUNE 2011)

Cerclage is too complex for a one-size-fits-all approach

It was gratifying to read the comments by Dr. Repke about the problems with meta-analysis. The literature on cerclage often overlooks important clinical variables.

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At one time, cerclage was not performed until three second-trimester preterm births had occurred. Thankfully, this approach is no longer considered valid; a single preterm birth is now a sufficient indication for cerclage.

A careful history is essential to determine whether the patient experienced labor in the previous pregnancy loss, to distinguish incompetent cervix from premature labor. A fair percentage of women who have an incompetent cervix do experience some labor—but usually not until the cervix has dilated 5 cm or more.

The timing of cerclage is critical. If it is performed at about 14 weeks' gestation, the procedure usually does not precipitate labor. However, if the OB is timid and waits until changes occur, the placement of cerclage frequently makes the situation worse by irritating the lower uterine segment. Occasionally, if suture is used, the cervix may be effectively amputated by a late-placed cerclage. The cerclage should not unduly constrict the opening of the os; the tip of the little finger should be able to enter.

Proper placement of the tape or suture is also essential. If it is placed too high, the surgeon risks penetrating the uterine artery. If the tape is placed too low, the cervical neck is insufficiently supported.

In a successful cerclage, the anchoring knot remains successfully buried; it may be wise, in these cases, to consider elective cesarean so that the knot can be left in place for future pregnancies.

Another important consideration is whether to use tape or suture. Tape is difficult to insert properly but offers wider support, whereas suture is easier to use.

All of these variables—the patient's history, timing and placement of cerclage, tape versus suture, and whether to leave the cerclage in place—should be addressed by the clinician. No single approach to cerclage fits all situations, including measurement of cervical length. Because so many variables go into the decision-making, meta-analysis yields questionable "conclusions," as Dr. Repke pointed out.

Kenneth W. McHenry, MD
Provo, Utah

›› Dr. Repke responds

Both the art and science of medicine are critical in management of cervical insufficiency

I appreciate the comments of Dr. McHenry, who very nicely points out how, in addition to applying the science of medicine to the problem of cervical insufficiency, we must still continue to apply the art. Many of the interesting points that he raises remain unresolved scientifically. The type of cerclage, type of suture (or tape), optimal timing, and optimal placement have all been addressed, but not satisfactorily, from a truly scientific standpoint. This lack of

definitive data underscores Dr. McHenry's point that one size does not fit all when it comes to cerclage.

"IN THE FIRST 5 MIN OF LIFE: OB AND NEONATAL MEDICINE PRACTICES ARE EVOLVING—IN WAYS THAT MAY SURPRISE YOU"
ROBERT L. BARBIERI, MD
(EDITORIAL; JUNE 2011)

Many benefits to delayed cord clamping

Delayed cord clamping is a reasonable practice because the baby is coming off "bypass," so to speak. It is especially useful as an adjunct to skin stimulation in newborns who have tight cords or poor thoracic skin capillary flow. Once the color returns, the cord may be clamped.

Michael Linzey, MD
Orange, Calif

Midwives adopted these neonatal practices long ago

Midwives have delayed cord clamping and abstained from bulb-syringe suctioning of all newborns for at least 23 years.

Kathryn Newburn, CNM, RNP
Burlingame, Calif

›› Dr. Barbieri responds

Delayed clamping is regaining prominence

I appreciate Dr. Linzey's view on the benefits of delayed cord clamping. Ms. Newburn makes the important observation that midwives are leaders in birthing practices. As I noted in my editorial, the practice of delayed cord clamping was advocated by leading obstetricians from the 1930s through the 1960s.[1,2] The practice waned, but is now likely to be resurrected.

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"A TALK ABOUT, THEN A PLAN FOR, ANTIDEPRESSANTS IN PREGNANCY"
DANIELLE CARLIN, MD, AND
LOUANN BRIZENDINE, MD
(MAY 2011)

Why was bupropion 'downgraded' to Pregnancy Category C?

In the past, bupropion (Wellbutrin) was a Pregnancy Category B drug and remained so long after the serotonin reuptake inhibitors (SRIs) were changed to Pregnancy Category C (Category D in the case of paroxetine [Paxil]). Many of my OB colleagues, therefore, began using bupropion. Why is the drug now considered "suspect"?

What other antidepressants would you consider using in pregnancy besides SRIs, if any?

Jonathan A. Fisch, MD
Indianapolis, Ind

›› Dr. Brizendine responds

We need more information on bupropion

Bupropion was moved from Pregnancy Category B to Category C because of the dearth of information about its effects in human pregnancy. According to a recent study, bupropion was used in the United States by 0.7% of women during pregnancy (the rate for SRIs was 3.8%).[1]

Bupropion does not cross the placenta, but its major metabolite, OH-bupropion, does. Neither bupropion nor its metabolite affect placental tissue viability or functional parameters, according to a recent study.[2]

As for first-trimester malformations, a recent Canadian study of 1,856 women (928 taking antidepressants and 928 in a comparison group) found 30 (3.2%) malformations among the group of women taking antidepressants, compared with 31 (3.3%) in the control group. The antidepressants taken by women in this analysis included bupropion (113), citalopram (184), escitalopram (21), fluvoxamine (52), nefazodone (49), paroxetine (148), mirtazepine (68), fluoxetine (61), trazodone (17), venlafaxine (154), and sertraline (61). ***None of these antidepressants were associated with an increased risk of major malformations above baseline. Only venlafaxine and paroxetine—but not bupropion—have been associated with an increased rate of spontaneous abortion.[3]***

The bottom line on bupropion in pregnancy? We need more information, but so far it has not been associated with an increased incidence of malformation or spontaneous abortion in humans.

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"IS THE ANNUAL PELVIC EXAM A RELIC OR A REQUISITE?"
BARBARA S. LEVY, MD (APRIL 2011)

Routine pelvic examination should include ultrasonography (US)

The stethoscope was invented in 1816 by a French physician, René-Théophile-Hyacinthe Laënnec. By amplifying cardiac and pulmonary sounds, he revolutionized evaluation of the heart and lungs. Until then, these organs were assessed by directly applying one's ear to the patient's chest.[1]

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When it comes to the bimanual pelvic exam, our specialty remains in the early 19th century, trying to discern between the two hands what is going on in the pelvis. A symptomatic patient will be referred for imaging regardless of the findings of this exam, but early pathology might be missed in an asymptomatic patient.[2]

The time has come to adopt US-assisted pelvic examination as routine. With some practice, this modality will prolong the office visit only minimally and save time and money overall.

In symptomatic patients, US-assisted pelvic examination can provide an immediate diagnosis in many cases, without the need for time-consuming and expensive referrals. The patient will have less anxiety and miss less time from work. An immediate diagnosis also reduces the number of telephone calls that need to be made.[3]

In asymptomatic patients, the detection of early pathology—be it an ovarian cyst, thickened endometrium, free fluid in the pelvis, or another pathology—will allow the physician to establish an early follow-up plan, improve management, and, in some cases, save lives.[4,5]

Some critics of this approach argue that the financial cost is excessive. However, I believe that endovaginal US, like the stethoscope, should be incorporated into the routine examination at no extra charge to the patient. In view of the large potential savings achieved by avoiding US referrals and extra office visits, I believe the insurance companies should consider subsidizing the equipment and accept a new code for US-assisted pelvic examination. It would be a win-win proposition for the health-care system, our patients, and the specialty.

Michael Harel, MD
New York, NY

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›› Dr. Levy responds

Routine ultrasonography increases costs

If transvaginal US were added to the routine pelvic examination, as Dr. Harel proposes, there is no doubt that the US probe would find cysts, fluid, and thickened endometrium in asymptomatic women. For symptomatic women, office-based transvaginal US in the hands of well-trained and experienced providers does enable rapid diagnosis and treatment. We have no idea, however, what the appropriate management or follow-up should be for asymptomatic women who have endometrial thickening (how much is too much and at what age?), fluid in the pelvis, or ovarian cysts (see the excellent four-part series on defining "normal" ovaries, by Ilan E. Timor-Tritsch, MD, and Steven R. Goldstein, MD, which appeared last year in OBG MANAGEMENT[1-4] and is available in the archive at obgmanagement.com). Far from reassuring our patients, these findings with uncertain clinical significance will undoubtedly create anxiety among the "worried well" and their providers.

The increased expense of this approach lies not in the cost of the US per se, but in the need for additional office visits and testing to "follow" the irregularities identified. Even in very high-risk patients, the use of US of the ovaries to screen for cancer has not been shown to improve outcomes.

That said, there may be some middle ground. The use of US to fine-tune the presumptive anatomic findings of the bimanual exam and to correlate the physiology of ovarian function (or lack thereof) with the endometrial response might enable a clinician to operate on a higher plane. However, if that clinician is using concepts that have not been validated (e.g., the questionable significance of simple ovarian cysts in postmenopausal women), then the incorporation of US into routine pelvic examination remains problematic.

If research demonstrates some advantage in detecting ovarian cysts, thickened endometrium, or pelvic fluid in patients with no symptoms, I could support the addition of routine US-guided pelvic examination. Absent guidelines for management of the expected cysts, fluid collections, and endometrial changes we will find in our asymptomatic patients, however, any improvement in the sensitivity of our exams with US will do nothing but drive costs, tests, and patient anxiety.

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