"WHEN CAN MRI MAKE THE DIFFERENCE FOR YOU IN DIAGNOSING A GYN ABNORMALITY?"
DEBORAH LEVINE, MD (JULY 2012)

Repeat the US before going to MRI

The July issue dropped into my email inbox just after I had ordered an MRI on a 17-year-old girl with a pelvic abscess that had been partially drained by an interventional radiologist. I agree with Dr. Levine that ultrasonography (US) is valuable in the evaluation of the female pelvis, and I caution providers not to fall into the trap of replacing sonographic skills with expensive technology.

Consider repeating the US with a skilled sonographer, radiologist, or gynecologist (ideally yourself) present in the room watching the scan as it is being performed—not looking at still images from the office. There are clinical pearls that cannot be reproduced in a still image, such as pain during the scan or movement of structures.

To make better use of our healthcare dollars, we need to maximize our clinical skills and get the most out of basic technology before jumping into expensive high-tech modalities.

Jose Carugno, MD
Orlando, Florida

"A STEPWISE APPROACH TO CERVICAL CERCLAGE"
KATRIN KARL, MD; MICHAEL KATZ, MD (JUNE 2012)

Cervical tension and retention of mucus also critical

I enjoyed reading the cerclage article by Dr. Karl and Dr. Katz in which the authors attempted to improve upon a decades' old surgical procedure.

Not only does the proper placement of the cerclage determine its effectiveness, but the tension of the cerclage is perhaps equally critical to

JULY 2012

prevent such complications as infection and membrane prolapse. While "tugging" on the cervix helps, having the patient in deep Trendelenburg position also facilitates the procedure. How the authors addressed this issue is not clear.

My experience has convinced me that preservation of pregnancy requires attention to uterine activity. Having corrected cervical incompetence, in order to assure that the pregnancy continues to term, one must ensure uterine tranquility. It is a well-known fact that premature births occur mostly among women without an incompetent cervix. Most of these births can be prevented if an obstetrician acts early and aggressively.[1]

Another fact I consider important is the retention of the cervical mucus, which may be crucial to prevent ascending infection and PROM. My aim always has been to restore the incompetent cervix to normal anatomy and physiology to assure that pregnancy comes to term.[2]

Stefan Semchyshyn, MD, MBA
Jonesborough, Tennessee

References

1. Semchyshyn S. Patients made key to successful prenatal care. Innovations. Tampa, FL: American College of Physicians Executives; 1993:231.
2. Semchyshyn S. A double cervical cerclage: Treatment of placenta previa. Paper presented at: 79th Annual Clinical Congress of American College of Surgeons; October 21-25, 1984; San Francisco, CA. 1984;35:453.

›› Dr. Katz responds

Retention of cervical mucus is important

We wish to thank Dr. Semchyshyn for his insightful comments. His suggestions are excellent and we do indeed follow them in terms of positioning of our patients in Trendelenburg inclination during the procedure. We also agree that retention of the cervical mucus may be an important issue and we always take special care to avoid/minimize manipulations in the cervical canal that may disturb or dislodge the cervical mucus.

"LAY MIDWIVES AND THE OBGYN: IS COLLABORATION RISKY?"
LUCIA DIVENERE, MA (MAY 2012)

An appalling lack of training for CPMs

I very much appreciated the article on lay midwives. As a certified nurse midwife student, I am horrified by the lack of training most certified professional midwives (CPMs) possess. Your article states: "The North American Registry of Midwives' [NARM] Portfolio Evaluation Process requires midwives to be the primary care provider during 50 home births and to have 3 years' experience. The average ObGyn resident gets this much experience in 1 month."

However, this is not the requirement one needs to become a CPM; this is more similar to the requirement to be a preceptor of CPMs—those who pass "knowledge" on to others!

Just this year, NARM began requiring a high school diploma for CPM certification. In addition, one

only needs to attend 10 births, assist at 20 births, be the primary midwife under supervision at 20 births, be the primary midwife under a qualified preceptor's supervision at five births, and complete additional requirements for prenatal, infant, and postnatal examinations.

To become a preceptor, you must have an additional 3 years' experience *or* 50 births as the primary midwife. The most recent NARM requirements can be found at: http://narm.org.

Heather Johnson
Portland, Oregon

"STOP PERFORMING MEDIAN EPISIOTOMY!"
ROBERT L. BARBIERI, MD
(EDITORIAL, APRIL 2012)

Have things come full circle?

I am so glad Dr. Barbieri addressed this issue. Since graduating in 2003, I have routinely used the mediolateral episiotomy as the only means to increase the perineal outlet for a difficult delivery. I found during my training that there were far too many "extensions" into third- and fourth-degree lacerations—great for learning how to repair them but difficult on the mother. At the time, there was only one attending who was cutting a mediolateral episiotomy. He quipped that the drawback was that it was a "difficult" repair. However, I find that it is far easier and more comfortable for the mother than a third- or fourth-degree extension!

I feel I'm in the minority when I use this method—as though I'm carrying on an "old school" tradition. But, now, after reading Dr. Barbieri's editorial, it seems to me that attitudes are coming full-circle. As we have moved from routine use of episiotomy to calling it a "surgical intervention," I am reminded daily of the nature of our job—to afford a safe and *healthy* delivery not only for the baby but the mother as well.

Lynn-Marie Aronica
Buffalo, New York

Perform mediolateral episiotomy when necessary

After practicing for 20 years, I know how to use forceps, so I always perform mediolateral episiotomy if I feel one is needed. Allowing the patient to tear is an acceptable alternative to performing an unnecessary small midline episiotomy. However, I would never perform a midline when there is a real risk of an extension.

Alison Wright, MD
Warner Robins, Georgia

›› Dr. Barbieri responds

Increased benefit to the mother

I thank Dr. Aronica and Dr. Wright for taking the time to share their perspectives on the role of episiotomy in obstetric practice. Our readers have a wealth of high-quality practice pearls developed during decades of clinical experience. The editorial team at OBG Management is very appreciative of our readers who write to share their insights with our physician audience.

I agree with Dr. Aronica that liberally performing median episiotomy, which was my past practice, gave us the opportunity to repair third- and fourth-degree extensions but may not have provided sufficient benefit to the mother to warrant the liberal use of the procedure.

I agree with Dr. Wright's recommendation that the combination of a planned operative vaginal delivery and an exam that suggests a large fetus should guide all obstetricians to strongly consider performing a mediolateral episiotomy, if an episiotomy is indicated, in order to reduce the risk of a third- or fourth-degree tear.