

apy. That precaution still holds. The patient should be an informed participant in the use of any drug during pregnancy.

If, as we believe, Wilson and Brent are basing reassurances regarding the lack of significant risk of hormones in pregnancy on critically flawed epidemiologic studies and erroneous assumptions of mechanisms of action of hormones, they are doing a disservice to practicing obstetricians, who may be encouraged into less conscientious use of hormones. Also, if they are wrong, as we believe they are, the ultimate disservice is in the potentially disastrous consequences to those yet to be born. It may be hoped that through dialogues of this type, we will continue to identify errors in design and execution of teratologic studies, profit from these errors, and demand better studies in the future. On the basis of the studies presently in the world literature, and until future adequately designed studies prove otherwise, we submit that the wisest course for obstetricians is still continued prudence.

James J. Nora, M.D., M.P.H.
Audrey H. Nora, M.D., M.P.H.
Paul Wexler, M.D.

Departments of Genetics, Preventive Medicine,
Pediatrics, and Obstetrics and Gynecology
University of Colorado School of Medicine
Denver, Colorado 80220

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Cervical dilatation with pessaries containing a new prostaglandin E₁ analogue in patients undergoing induced abortion

To the Editors:

It was with great interest that I read the article, "Low-dose vaginal 15 methyl prostaglandin F_{2α} for cervical dilatation prior to vacuum curettage abortion," by Drs. Niloff and Stubblefield (*AM. J. OBSTET. GYNECOL.* **142**:596, 1982).

Surgical abortion through the vagina is performed by dilating the cervix with Hegar graduated dilators and mechanically removing the products of conception by curettage or by the technique of vacuum aspiration, or both. Cervical incompetence, spontaneous abortion, premature labor, and other complications have been reported by some workers among patients who have undergone surgical abortion. There is a need to minimize the risk of damage to the cervix during mechanical dilatation.

Recently, several investigators have reported the use of prostaglandin E₂ or F_{2α} to soften the cervix before suction curettage. Moreover, some prostaglandin analogues have already proved superior in terms of safety, greater oxytocic effect, longer duration of action, and lesser side effects. In their article, Drs. Niloff and Stubblefield stated that 15-methyl-prostaglandin F_{2α} used for a 3-hour interval produced adequate cervical dilatation with few side effects in induced abortion.

In our clinic, a new prostaglandin E₁ analogue, 16,16-dimethyl-*trans*-Δ²-PGE₁ methyl ester (16-me-E₁) was used for preoperative cervical dilatation in 23 pregnant women who had abortion induced for socio-economic reasons in the first trimester of pregnancy. A single vaginal pessary containing 1 mg of 16-me-E₁ was inserted into the posterior fornix at 3-hour intervals. Thirteen (56.5%) of the 23 patients had complete abortions and two patients (8.7%) had incomplete abortions. In six patients (26.1%) the cervix was dilated to at least 10 mm. The remaining two patients (8.7%) required mechanical dilatation at the time of vacuum evacuation. Apart from mild gastrointestinal symptoms, no serious side effects were noted. It is concluded that the new prostaglandin E₁ analogue, 16-me-E₁, could be used safely and effectively for preoperative dilatation of the cervix before surgical abortion in early pregnancy.¹

Ryosuke Nakano, M.D.

Department of Obstetrics and Gynecology
Wakayama Medical College
Wakayama 640, Japan

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Iatrogenic prematurity with elective repeat cesarean section

To the Editors:

Dr. Bowers and associates are to be congratulated on their highlighting of the widespread problem of iatrogenic prematurity with elective repeat cesarean sections. It is now clear that gestational age is difficult to document with certainty by any parameter. Ultrasonic

devices can give us biparietal and other diameters with accuracy. Can we, however, equate biparietal diameter (BPD) or fetal size in general with pulmonary surfactant maturity? Clearly, we cannot. Witness the macroscopic infant of a diabetic mother who develops the respiratory distress syndrome (RDS) with a BPD greater than 95 mm.

We think that the best current method for assessing the fetus's ability to breathe adequately after birth is the assessment of surfactant phospholipids in the amniotic fluid, the lecithin/sphingomyelin ratio, and, particularly, phosphatidylglycerol (PG). In a series now exceeding 500 amniocenteses, we have had only two infants develop RDS when PG was present in the amniotic fluid. One of these was a septic baby, and the other was the premature infant of a mother with lupus nephritis who was on a regimen of steroids in large doses.

We challenge the statement that amniocentesis near term carries a 1% risk to the fetus; it is certainly much lower than that, particularly, as noted by the authors, when performed under ultrasonic guidance.

We agree with the authors that rupture of a previous uterine scar with labor is a rare event. In a recent review of 80,183 deliveries, 10,691 of which were cesarean sections, only six cesarean hysterectomies were performed for uterine rupture, only three of which involved rupture of a previous cesarean section scar. There was asymptomatic significant dehiscence of a previous section scar in eight additional cases. When assessment of pulmonary surfactant phospholipids is not available or amniocentesis fails, we await the onset of labor as the safest policy for the baby, provided that the mother has prompt access to the hospital. If the previous cesarean section was for a nonrecurring cause, we might even elect an attempt at vaginal delivery and expect to succeed in 50% of cases.

Whether one allows labor or determines surfactant levels in amniotic fluid, the thing one must not condone is the delivery of premature babies who develop RDS because of elective cesarean section at some arbitrary gestational age. We congratulate the authors on bringing this problem to the attention of the specialty in this age of doggedly increasing cesarean section rates.

Warren C. Plauché, M.D.

Department of Obstetrics and Gynecology
Louisiana State University Medical Center
1542 Tulane Avenue
New Orleans, Louisiana 70112

Reply to Dr. Plauché

To the Editors:

We appreciate Dr. Plauché's comments and agree both that gestational age is difficult to estimate with certainty and that fetal size does not necessarily correlate with pulmonary maturity. Furthermore, even "term" infants who are delivered by elective repeat cesarean section are at risk for the respiratory distress

syndrome. Indeed, in our series, 29 affected infants (41%) were judged to have been delivered at term.

Determination of amniotic fluid phosphatidylglycerol is clearly a useful method of evaluating fetal pulmonary maturity. We believe that awaiting the onset of labor at term is a reasonable alternative to invasive testing.

In choosing between these approaches, one must balance their associated risks. Amniotic fluid phosphatidylglycerol is a relatively new test. As with most new diagnostic tests, as the spectrum of patients to whom the test is applied broadens, the percentage of false positive results is likely to increase.¹ There is also the problem of laboratory error and the possibility that the specimen will be lost. Although the overall risk of serious injury to the fetus from amniocentesis is probably less than 1%, there clearly is a risk. In addition, some women refuse to undergo the procedure.

The frequency of uterine rupture when a woman who has had a previous low transverse cesarean section is allowed to undergo labor is approximately 0.5%, which is about the same as the frequency of uterine rupture at the time of scheduled cesarean section.² Other potential risks which may be associated with allowing these women to initiate labor spontaneously include an additional anesthetic risk in a patient who may have recently eaten and a possible increased frequency or duration of postpartum fever. These potential risks have not been adequately studied. The monetary cost of this latter approach is clearly far less than that of performing amniocentesis with ultrasound and phospholipid testing.

We agree with Dr. Plauché that either approach is acceptable, and that elective cesarean delivery at an arbitrary gestational age, without prior evidence of fetal pulmonary maturity, is to be avoided.

Susan K. Bowers, M.D.

Community Health Care Plan
150 Sargent Drive
New Haven, Connecticut 06511

Eugene D. Shapiro, M.D.

Clinical Scholars Program
Yale University School of Medicine
New Haven, Connecticut 06510

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Importance of sinusoidal fetal heart rate pattern

To the Editors:

In their recent article, "Sinusoidal fetal heart rate pattern: Its definition and clinical significance" (*AMERICAN JOURNAL OF OBSTETRICS AND GYNECOLOGY* **142**: