A VBAC question

To the Editors: The article by Blanchette et al[1] proved thought provoking. Contained within were seven points that can be used as a guide toward a safe vaginal birth after prior cesarean section. These points were presented in a clear and pragmatic manner. The danger with an article that makes one think is the questions that arise in the reader's mind. One question would be, why not add pelvic assessment?

The use of x-ray pelvimetry to assess the pelvis can be argued against by use of literature examples, such as increased cesarean section rate or fetal damage. Use of this technique either before pregnancy or just after the first cesarean section would be one way around some of these arguments. Another would be the use of the De Lee pelvimeter to measure anteroposterior diameter at the time of the first cesarean section as part of the pelvic assessment. This simple instrument does not add the risk of an x-ray technique and provides a quantitative measure that can be used to guide future decision making.

Jorge O. Escamilla, MD

204 Sunset Dr, Brooksville, FL 34601

REFERENCE

1. Blanchette H, Blanchette M, McCabe J, Vincent S. Is vaginal birth after cesarean safe? Experience at a community hospital. Am J Obstet Gynecol 2001;184:1478-87.

6/8/121658
doi:10.1067/mob.2002.121658

Reply

To the Editors: In response to Escamilla's recommendation that pelvic assessment be added to the list of seven optimal conditions for a safe and successful trial of labor after cesarean section, we would suggest that the use x-ray pelvimetry or the De Lee pelvimeter may not be helpful. The prognosis for successful vaginal delivery in any given pregnancy cannot be established on the basis of x-ray pelvimetry alone because the pelvic capacity is but one of several factors that determine the outcome.[1] Additionally, 50% to 70% of patients with a prior cesarean section for dystocia are successfully delivered vaginally after a trial of labor after prior cesarean section. A clinically adequate pelvis is one of the current criteria useful in identifying candiates for vaginal birth after cesarean section.[2]

Howard Blanchette, MD

Department of Obstetrics and Gynecology, Danbury Hospital, 24 Hospital Ave, Danbury, CT 06810

REFERENCES

1. Cunningham, et al. Williams' obstetrics. 21st ed. Dystocia: abnormal and fetopelvic disproportion. New York; McGraw-Hill; 2001. p. 438.
2. Vaginal birth after previous cesarean delivery. Washington (DC): American College of Obstetricians and Gynecologists; 1999. ACOG Practice Bulletin No.: 5.

6/8/121657
doi:10.1067/mob.2002.121658

Obstetrician-gynecologists performing genetic amniocentesis may be misleading themselves and their patients

To the Editors: We are writing to confirm and support the observations of Blessed et al.[1] We have reviewed the experience with genetic amniocentesis at Phoenix Perinatal Associates. From August 1999 to June 2001 we performed 1496 midtrimester amniocenteses for genetic diagnosis. There were three losses within 2 weeks of the procedure, for a loss rate of 1:499. Seventeen patients had postprocedure leaking of fluid, which resolved, and the pregnancy continued without problems.

We support the authors' conclusion that, in the hands of physicians doing large numbers of procedures, genetic amniocentesis is safer than previously published studies have suggested.

William H. Clewell, MD, Ann Bogle, PhD, Nicole Weston, MS, and Susan Greensher, MS

Division of Maternal-Fetal Medicine, Good Samaritan Medical Center, 1111 E McDowell Rd, Phoenix, AZ 85006

REFERENCE

1. Blessed WB, Lacoste H, Welch RA. Obstetrician-gynecologists performing genetic amniocentesis may be misleading themselves and their patients. Am J Obstet Gynecol 2001;184:1340-4.

6/8/121655
doi:10.1067/mob.2002.121655

Reply

To the Editors: We thank Dr Clewell for his letter supporting our study and conclusions. Our study confirms previous reports that increased experience in performing invasive procedures is associated with fewer complications. Since the publication of our findings, other groups confirming our findings have contacted us. We hope that our study stimulates clinicians to critically evaluate their own performance to determine whether they are really providing the best care or if they are "misleading themselves and their patients."

William B. Blessed, MD, and Robert A. Welch, MD

Providence Maternal Fetal Diagnostic Centers, Providence Pavilion, 22255 Greenfield Rd, Suite 350, Southfield, MI 48075

6/8/121656
doi:10.1067/mob.2002.121655

Low maternal plasma volume may be the answer!

To the Editors: Bukowski et al have shown that a significant proportion of fetuses destined for preterm delivery do not reach their growth potential, a relationship that was previously proposed.[1,2] The authors have ignored the concept that this relationship might represent two effects of inadequate maternal plasma volume expansion.[2] Failure to adequately expand maternal plasma volume has several additional clinical symptoms, including hemoconcentration (high hematocrit) and decreases of amniotic

fluid volume, dependent edema, and pulmonic systolic murmur.[3] Sometimes such simple measures as increased fluid intake can increase maternal plasma volume.

Robert C. Goodlin, MD

1897 Country Club Dr, Placerville, CA 95667-6026

REFERENCES

1. Bubowski R, Gahn D, Denning J, Saade G. Impairment of growth in fetuses destined to deliver preterm. Am J Obstet Gynecol 2001;185:463-7.
2. Goodlin RC, Quaife MA, Dirksen JW. The significance, diagnosis, and treatment of maternal hypovolemia as associated with fetal/maternal illness. Semin Perinatol 1981;5:153-74.
3. Goodlin RC, Dorby CA, Anderson JC, Woods RE, Quaife MA. Clinical signs of normal plasma volume expansion. Am J Obstet Gynecol 1983;146:505-11.

6/8/121660
doi:10.1067/mob.2002.121660

Reply

To the Editors: We would like to thank Dr Goodlin for his interest in our study. We reported on the high proportion of fetuses with severe impairment of the individual growth potential among ones delivered preterm. We decided not to speculate on the nature of the possible mechanism underlying this impairment because the evidence in this area is sparse and candidate theories are plentiful. Certainly, inadequate maternal volume expansion qualifies as one of the possible mechanisms.

Radek Bukowski, MD, PhD, and George R. Saade, MD

Department of Obstetrics and Gynecology, University of Texas Medical Branch, 301 University Blvd, Galveston, TX 77555-0587

6/8/121659
doi:10.1067/mob.2002.121660

Surgical repair of cystocele with mesh by the vaginal route

To the Editors: We read with interest the article by Sand et al.[1] This prospective randomized trial studied the efficacy and safety of an absorbable mesh for the surgical repair of cystocele by the vaginal route. The authors concluded that this mesh is safe and effective. Although their study design was excellent, the rate of recurrent cystocele in both groups is unacceptably high: after 1 year, they reported 43% recurrence of grade 2 to 3 cystocele without mesh and 25% with mesh.

Previous studies have shown <10% recurrence of grade 2 to 3 cystocele with no mesh.[2] Furthermore, a mesh should be indicated for some patients with a high cystocele recurrence risk: cystocele of grade 3 to 4 or previous reparative failure. Julian[3] has shown in a randomized study of 24 patients with a 2-year follow-up that a polypropylene mesh (Marlex, Bard Vascular System Division, CR Bard, Billerica, Miss) was more effective than no mesh. In this study, 3 patients of 12 in the mesh group had vaginal erosion within 6 months after surgery, but for 2 of these this adverse effect was easily treated without subsequent consequences. Migliari et al,[4] in other 12 patients, showed a 100% cure rate of cystocele with another polypropylene mesh (Prolene, Gynemesh, Gynecare, Ethicon, Issyles-Moulineaux, France) with a median follow-up of 20.5 months, and with no vaginal erosion.

We have performed in our institution, between October 1999 and March 2001, 36 procedures for cystocele repair by the vaginal route with use of Prolene mesh. All patients had grade 3 to 4 cystocele, according to the Baden-Walker classification, and 2 patients had had one previous reparative failure. Our preliminary results, with a median follow-up of 13 months (range 6 to 23 months), show a 100% cure rate of cystocele. One patient (2.8%) was found to have a 30 × 10 mm vaginal erosion 6 weeks after the operation. We have performed a conservative management by excision of the visible part of the mesh under local anesthesia, with no recurrence of the erosion 1 year later.

We suggest that most recurrences of cystocele should be eliminated using the polypropylene mesh, which has an acceptable risk of adverse effect that is directly dependent on the surgical technique use for the mesh placement.

Renaud de Tayrac, MD, and Hervé Fernandez, MD

Department of Obstetrics and Gynecology, Antoine Beclere University Hospital, 157 rue de la porte de Trivaux, 92140 Clamart, France

REFERENCES

1. Sand PK, Koduri S, Lobel RW, Winkler HA, Tomezsko J, Culligan PJ, et al. Prospective randomized trial of polyglactin 910 mesh to prevent recurrence of cystoceles and rectoceles. Am J Obstet Gynecol 2001;184:1357-64.
2. Shull BL, Bachofen CG, Coates KW, Kuehl TJ. A transvaginal approach to repair of apical and other associated sites of pelvic organ prolapse using uterosacral ligaments. Am J Obstet Gynecol 2000;183:1365-74.
3. Julian TM. The efficacy of Marlex mesh in the repair of severe, recurrent vaginal prolapse of the anterior midvaginal wall. Am J Obstet Gynecol 1996;175:1472-5.
4. Migliari R, De Angelis M, Madeddu G, Verdacchi T. Tension-free vaginal mesh repair for anterior vaginal wall prolapse. Eur Urol 2000;38:151-5.

6/8/122094
doi:10.1067/mob.2002.122094

Reply

To the Editors: We greatly appreciate the letter by de Tayrac and Fernandez regarding our article. Note that our report of recurrent cystoceles to the midvaginal plan and to the hymenal ring included any relaxation of the anterior vaginal wall. This demonstrates the importance of the control group. Clearly, our assessment of recurrent anterior vaginal wall prolapse is far more rigorous than the other report quoted. Please note that no recurrent prolapse beyond the hymenal ring was noted at all in this trial and only 11% of the controls had prolapse to the hymenal ring, with only 3% in the mesh intervention group. These data are certainly consistent with the results previously reported by Shull et all, which you quoted. We also