

and specificity that are inherent in utilizing a specific threshold for further evaluation, and understanding the resources available in a particular clinical context helps to inform these decisions.

In the current study, we employed a cut-off score of ≥ 12 for further mental health evaluation to increase sensitivity both antepartum and postpartum, and to minimize missing women at risk. Women only underwent further treatment for depression following a formal psychological assessment after screening positive. Importantly, this study demonstrated the feasibility to implement a universal depression screening program within the context of existing clinical resources devoted to routine antepartum and postpartum obstetrical care. We agree that accurate scoring of the EPDS is critical to any screening program. Beyond routine implementation of EPDS administration, we agree that there is a need to enhance the efficacy, equity, and efficiency of screening by optimizing provider training and gaining a greater understanding of the best timing for administration as well as the optimal cut-offs for different populations. ■

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Urinary incontinence after hysterectomy



TO THE EDITORS: We read with interest the article of Bohlin et al¹ about urinary incontinence (UI) after hysterectomy. Based on a large cohort study, the authors stated that several factors, including vaginal delivery, body mass index, and preoperative urgency, influenced the rate of UI after hysterectomy. However, the authors did not underline the confusion made between urge UI (UUI) and stress UI (SUI). It is mandatory to comment on this point, because the absence of distinction between UUI and SUI can be misleading for several reasons.

First, distinguishing SUI and UUI (and their association, called mixed incontinence) is of importance because both are highly prevalent and often associated. The prevalence of overactive bladder (OAB), ie, urgency with or without incontinence, is estimated to be 11.8%,² varying from 1.8-30.5% in a recent article by Milsom et al.³ Separating SUI and UUI would thus have led to groups of similar size based on patient characteristics and would have likely influence the results in a logistic regression analysis.

Then, the pathophysiology of UUI and SUI is completely different, as are the therapeutic resources.⁴ While SUI has a complex but known interaction with pelvic organ prolapse, UUI belongs to the field of OAB and has very unclear links with pelvic organ prolapse and other gynecologic disorders, based on low-level inconsistent evidence.⁵

Lastly, the authors consider “daily urge” as a criterion in their logistic regression analysis. As a component of OAB, but not necessarily associated with UUI, this parameter cannot be interpreted correctly in the current context. Indeed, this

category can reflect OAB without incontinence, that is idiopathic in the vast majority of cases and would not be impacted by hysterectomy. On the other hand, this category of “daily urge” surely includes all patients with UUI, but their proportion can only be postulated. Unfortunately, this “daily urge” status is not available in the postoperative setting. Furthermore, the absence of data regarding antimuscarinic therapy is also another important caveat.

Not taking into account that UUI and SUI are 2 different diseases blurs the analysis and limits sound conclusions. ■

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REPLY



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We thank Dr Jean-Nicolas Cornu and colleagues¹ for their comments regarding our article entitled “Factors influencing the incidence and remission of urinary incontinence after hysterectomy”² published in the *American Journal of Obstetrics and Gynecology*.

Our study showed that hysterectomy clearly influenced urinary incontinence (UI), as one fifth of the women experienced a change in their continence status post-hysterectomy. Vaginal delivery, obesity, and daily urge symptoms without incontinence prior to surgery increased de novo UI and had a negative influence on the rate of remission of UI after hysterectomy, which in turn influenced patients’ satisfaction with surgery. De novo UI is a negative consequence of hysterectomy and remission of UI can be seen to be a positive development. Both are of importance when counselling patients contemplating a hysterectomy.

The study focused on the presence of UI and not the type of UI. We are well aware of the differences between types of incontinence and in this respect there was no “confusion” on our part. For our patients the occurrence of urinary leakage irrespective of whether it is of stress urinary type or of urge type is a highly disturbing issue.

Both stress UI and urge UI are common in women, however the relative proportions of these 2 types of incontinence do vary with age.³ The prime aim of our study was to describe the incidence and remission of UI in women undergoing hysterectomy. In addition we studied possible

factors influencing the incidence and remission rates of UI. One of the factors included in the logistic regression was the experience of daily urinary urge prior to hysterectomy in women without incontinence. Dr Cornu and colleagues correctly pointed out this could also have been expressed as overactive bladder without UI prior to surgery. Our study indicated that these women had a greater risk of incontinence following surgery, which is important knowledge for doctors and patients when considering a hysterectomy.

It would have been of interest to know to what extent antimuscarinic medication was being used but this information was not available in the data base.

In conclusion, because we analyzed UI alone without separation into stress UI or urge UI, we do not consider the analyses “blurred,” as our specific aim was to study the influence of hysterectomy on the incidence and remission of UI, which was clearly presented. ■

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Comment on treatment for recurrent vulvovaginal candidiasis



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TO THE EDITORS: With great interest we read the article “Recurrent vulvovaginal candidiasis” of Jack D. Sobel.¹ The author presents oral and topical treatment strategies for recurrent vulvovaginal candidiasis. Therapy with oral fluconazole starts with an initial “induction therapy” and is followed by a maintenance phase, wherein the drug is given at certain intervals.^{2,3}

Although a systematic review confirms the advantage of the use of weekly fluconazole for 6 months,² we missed the emphasis on the advantages of another, more individualized and patient-centered regimen that is common in Europe.³ In this regimen, the total dose of fluconazole is more individualized to the outcomes (“ReCiDiF” regimen).³