Invasive diagnosis after first-trimester aneuploidy screening

We are grateful to the authors of this letter to the Editor for the interest shown in our study.1 In our study, we have shown that the identification of increased nuchal translucency (NT) ≥3.0 mm and ≥3.5 mm can also be reliably performed using axial planes in women in the first trimester of pregnancy. Patients were recruited from the population undergoing a larger trial promoted by the health authorities of the Emilia Romagna region to compare the performance of the combined test with that of noninvasive prenatal testing (NIPT) for trisomies of chromosomes 21, 18, and 13. According to the protocol of the study, an invasive procedure was offered to patients that had a positive combined test (risk of trisomy 21 >1:300, risk of trisomy 13 or 18 >1:150), a positive NIPT, or a NT of ≥3.5 mm. Among the 1023 women of our study, 14 (1.4%) had an NT of 3.5 mm, and 2 (0.2%) had NTs of 3.0 mm and 3.4 mm, respectively. Forty-five (4.4%) had a high risk of aneuploidies at the combined test or at the NIPT. All the 16 fetuses with an NT of >3.0 mm were in the latter group of high risk, whereas the other 29 presented an NT within normal ranges. We did not find any fetus with an increased NT and a low risk of aneuploidies by NIPT or combined test. Among the women with high-risk aneuploidy screening, 33 decided to have chorionic villus sampling, with 6 (18%) anomalies detected. There were 3 cases of trisomy 21, all with an increased NT (3.7 and 4.4 mm, respectively, and one with generalized hydrops). The fetus with trisomy 9 had a very enlarged NT with septations and severe hydrops; the pregnancies with trisomy 16 had no anatomic malformation detectable on first-trimester ultrasound.

The results of our study are well-correlated with previous experience that the identification of increased NT is a crucial part of the first-trimester ultrasound,2,3 most of all because these fetuses have a high risk of aneuploidy and may be addressed directly to the determination of the fetal karyotype. We stress again that our study did not aim to suggest that sagittal planes are replaced by transverse views in the precise quantification of NT required for combined test risk assessment. In pregnancies undergoing NIPT instead, NT assessment may be initiated in the transverse plane, particularly in cases with the fetus in unfavorable position, limiting a sagittal view for cases with an excessive measurement.

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Prevention of umbilical cord prolapse in high-risk patients

TO THE EDITORS: I compliment Wong et al for providing a detailed review of an uncommon but life-threatening fetal obstetrical emergency—a prolapsed umbilical cord.1 The authors addressed the importance of the need of balancing maternal risk of emergency cesarean delivery with the fetal risk of hypoxia. In cases of extreme prematurity, delaying delivery has been reported as an exception to the rule with favorable outcomes.2 The authors carefully described the maneuvers used to manage umbilical cord prolapse, including manual elevation of the presenting part, placing the patient in the Trendelenburg position, filling of the maternal bladder, among others. However, despite known risk factors for
FIGURE

Multiple loops of umbilical cord below the presenting part. Cervical cerclage prevents it from prolapsing

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Does simulation really increase gynecologic surgical skill?

TO THE EDITORS: We read with interest the article by Orejuela et al evaluating the effect of simulation training on learner operative skills in gynecologic surgeries. The authors concluded that simulation-based training could improve operative skills, and had a moderate quality of evidence. However, we would like to highlight the following methodological concerns of these results.

The authors pooled the results of randomized controlled trials (RCTs) and nonrandomized comparative studies (NRCs) together, which may introduce bias because of their methodological differences. We therefore performed a subgroup analysis on the basis of study design (Supplemental Figures 1–3) and found that there are differences in the effect estimates between NRCs and RCTs among 3 meta-analyses. In Supplemental Figures 1 and 3, the NRCs showed a considerable difference, whereas the RCTs did not. In Supplemental Figure 2, a markedly small effect of a decrease was found in the pooled result, irrespective of the study design. However, there was no significant difference in the subgroups of both NRCs and RCTs. Therefore, we believe that the NRCs and RCTs should not simply be pooled in a single metaanalysis. The conclusions on the effectiveness of simulation-based training could be considered misleading and might lack clinical relevance, as RCTs are more likely to provide unbiased information than NRCs.

In addition, the authors did not correctly use the Grading of Recommendations Assessment, Development, and Evaluation (GRADE) approach and did not report each factor for downgrading and upgrading the quality of evidence explicitly and transparently. First, according to the GRADE methodology, the quality of RCTs and NRCs should be assessed separately, and the final assessment result should be presented by considering the results of RCTs and NRCs comprehensively. Please note, we only present the results of the RCTs, because