

Cervical length in high-risk pregnancies

To the Editors: I read with interest the work of Iams et al. (Iams JD, Johnson FF, Sonek J, Sachs L, Gebauer C, Samuels P. Cervical competence as a continuum: A study of ultrasonographic cervical length and obstetric performance. *Am J Obstet Gynecol* 1995;172:1097-106) and agree with their conclusion that cervical competence is a continuum. There are two points I would like to raise. First, as the authors discussed, the results may be complicated by the variable use of cerclage in each of the individual "reproductive history" groups. They report the differences in cervical length at each gestational age in the current pregnancy between women with or without cerclage. However, it would be interesting to know whether there was any difference in cervical length between the two groups (with or without cerclage) on the basis of "reproductive history." In other words, did the 42% of women whose first preterm birth was delivered before 26 weeks and who did not undergo cerclage in the current pregnancy have any difference in cervical length measurements compared with the 58% who received a suture? Cervical change after cerclage has been demonstrated by several authors,¹ but what remains unclear is whether the operation actually prevents or reduces subsequent shortening. There is an obvious paucity of randomized trials comparing surgical with nonsurgical management in this situation. Second, a cervical length of ≤ 25 mm is commonly being quoted as the diagnostic criteria for a short cervix.² I note that most of the "reproductive history" groups reached this cervical length at approximately the same gestational age in the current pregnancy as in their first preterm births, possibly implying an element of biologic timing.

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REFERENCES

1. Andersen HF, Karimi A, Sakala EP, Kalugdan R. Prediction of cervical cerclage outcome by endovaginal ultrasonography. *Am J Obstet Gynecol* 1994;171:1102-6.
2. Iams JD, Goldenberg RL, Meis PJ, et al. The length of the cervix and the risk of spontaneous prematurity. *N Engl J Med* 1996;334:567-72.

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Response declined**Life tables without confidence intervals may mislead**

To the Editors: We agree with Unger and Meeks (Unger JB, Meeks GR. Hysterectomy after endometrial ablation. *Am J Obstet Gynecol* 1996;175:1432-7) that further long-term

Table 1. Calculated 95% confidence intervals for data of Unger and Meeks

Interval No.	Cumulative probability of avoiding hysterectomy (%)	Confidence interval (%)
1	97.6	± 5.8
2	87.8	± 26.8
3	80.5	± 38.9
4	70.8	± 51.0
5	65.7	± 54.9

studies are needed to define the role of endometrial ablation for menorrhagia. We take issue with their conclusions and inferences, principally on the ground that these are based on the results obtained from a study of 41 women. They report that 34% of their patients underwent hysterectomy within 5 years of the initial surgery, a higher rate than shown in other studies.¹ Our study of endometrial resection with use of life tables reported a 20% risk of requiring further surgery by 5 years, and 9% of our patients had hysterectomy, some opting for repeat resection. Furthermore, 98% of repeat surgery occurred in the first 3 years and there was no linear relationship between the rate of further surgery and time.

There are several explanations why the results of Unger and Meeks are at variance with other published data. There is some evidence that endometrial resection is more effective in long-term relief of menorrhagia than rollerball ablation is. Operator experience can have a major influence on outcome, and it is unclear whether the cases reported were part of the learning curve. Unger and Meeks found no effect of patient age on the risk of treatment failure, in contrast to several publications showing that younger women do less well.

The small size of the study of Unger and Meeks seems the key to why care must be taken in interpreting their results. They do not give confidence intervals for their life-table analysis. We calculated the 95% confidence intervals for their data, and they show that, because the overall study group is so small, the intervals with respect to the cumulative risk of hysterectomy are very large (Table 1). Their results have to be taken in the context of these figures, which shows that it is impossible to judge from this study the efficacy of endometrial ablation. It is also inappropriate to extrapolate their results over the next 5 to 8 years.

It is now 16 years since the first report of hysteroscopic endometrial ablation by Goldrath et al.² Since then, carefully controlled prospective randomized trials with hysterectomy have confirmed the many advantages, both clinical and financial, of hysteroscopic surgery.³ We commend Unger and Meeks on their use of life tables, but their study has insufficient power to put these results into question.

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