

Miklos and Saye assumed a general success rate of 85% for the Burch colposuspension. However, I take the liberty of remembering that none of our patients had undergone previous surgery and that those with urethral sphincter weakness or detrusor instability were excluded. This means that our population represents selected patients with primary uncomplicated pure genuine stress incontinence. Moreover, subjects were followed up for a relatively brief period. I believe that in such circumstances a success rate around 95% should be presupposed.^{2, 3}

We began our trial with the conviction that the paravaginal repair would have been an excellent antiincontinence operation. I now discourage its use in treating stress incontinence. Nonetheless, I do not believe that it should be excluded from our surgical armamentarium. At our institution we are continuing to perform the paravaginal repair but exclusively in continent patients (or those with only minimal degrees of incontinence) with a cystocele from a lateral defect who are undergoing abdominal surgery for other reasons.

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REFERENCES

1. Peipert JF, Metheny WP, Schulz K. Sample size and statistical power in reproductive research. *Obstet Gynecol* 1995;86:302-5.
2. Penttinen J, Kaar K, Kauppila A. Colposuspension and transvaginal bladder neck suspension in the treatment of stress incontinence. *Gynecol Obstet Invest* 1989;28:101-5.
3. Kilholma P, Mäkinen J, Chancellor MB, Pitkänen Y, Hirvonen T. Modified Burch colposuspension for stress urinary incontinence in females. *Surg Gynecol Obstet* 1993;176:111-5.

6/8/78533

Efficacy of methotrexate

To the Editors: I was pleased to read the article by Stika et al. (Stika CS, Anderson L, Frederikson MC. Single-dose methotrexate for the treatment of ectopic pregnancy: Northwestern Memorial Hospital three-year experience. *Am J Obstet Gynecol* 1996;174:1840-8.) The results of Stika et al. showing only a 64% success rate of resolution of ectopic pregnancy with a single methotrexate injection contrasts with the 85% to 95% success rates of other authors.

In fact, there are few reports showing limited success with methotrexate. In our study¹ 50 mg of methotrexate was injected directly into a laparoscopically confirmed ectopic pregnancy. Of 44 patients treated this way, only 27 (61.4%) had successful resolution and 17 (38.6%) required a further procedure, usually salpingostomy or salpingectomy.

Treatment for ectopic pregnancy by methotrexate requires the patient to be under prolonged observation, with failure occurring up to several weeks after the

injection, even in the face of decreasing β -human chorionic gonadotropin levels. These patients must be carefully selected and counseled. It is probable that when other centers review their results with single-dose methotrexate, they will find a success rate below the classically reported 97% reported by Stovall and Ling.²

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REFERENCES

1. Shalev L, Peleg D, Bustan M, Romano S, Tsabari A. Limited role of intratubal methotrexate treatment of ectopic pregnancy. *Fertil Steril* 1995;63:20-4.
2. Stovall TG, Ling FW. Single-dose methotrexate: an expanded clinical trial. *Am J Obstet Gynecol* 1993;168:1759-65.

6/8/78615

Endoscopic coverage of fetal open myelomeningocele in utero

To the Editors: Harrison was mistaken when he stated that endoscopic coverage of myelomeningocele has not yet been attempted in human fetuses (Harrison MR. Fetal surgery. *Am J Obstet Gynecol* 1996;174:1255-64). In fact, we have successfully performed an experimental procedure designed to prevent ongoing exposure of the spinal cord to amniotic fluid in two patients at Vanderbilt University Medical Center. This minimally invasive fetal surgery was developed by us in pregnant mixed-breed ewes.¹ The technique we designed consists of placement of a maternal split-thickness skin graft over the exposed neural placode. The skin graft and a covering of oxidized regenerated cellulose (Surgicel, Johnson & Johnson Medical, Arlington, Tex.) are attached in a carbon dioxide atmosphere with fibrin glue prepared from autologous cryoprecipitate.

Two fetuses with open lumbar myelomeningocele underwent endoscopic coverage of the spinal lesion at 22 and 23 weeks' gestation. One infant, delivered by planned cesarean section at 35 weeks' gestation after demonstration of fetal lung maturity, is 1 year old. The other fetus was delivered 1 week after operation because of the development of amnionitis and died in the delivery room of extreme prematurity.²

A growing body of evidence suggests that, in addition to the congenital neurologic defects associated with the development of myelomeningocele, spinal cord injury may result from prolonged exposure of the neural elements to amniotic fluid.³ In several animal models the clinical and pathologic manifestations of surgically induced "myelomeningocele" were prevented by in utero repair.¹ We are currently conducting in vitro research in an attempt to identify the timing and etiologic agents of the environmental insult more precisely. In the meantime we agree that surgical treatment of this nonlethal defect is not justified with a standard hysterotomy approach, because of the unacceptably high morbidity and mortality associated with open fetal surgery. Minimally