TO THE EDITOR:

I note a small opportunity for misunderstanding in our article: Klein MC, Janssen PA. Factors influencing perineal trauma during delivery. J Soc Obstet Gynaecol Can 1998;20(2):149-56.

In the discussion in the last paragraph, we were making the distinction between women who have a strong exercise profile and those who do not. Women with a strong exercise profile would be relatively protected against a third of fourth degree tear if they go to a physician who uses episiotomy routinely, i.e. they are less likely than non-exercisers to have an extension to a third of fourth degree tear (presumably because they have good tissue quality). On the other hand, if such a woman is attended by a physician whose practice style is to limit episiotomy use, she will be more likely to have a perineum requiring no stitching (again, based on good tissue quality).

What is required for women with a strong exercise profile is a physician who will wait for the perineum to stretch which will take a few extra contractions. The myth that **thick perineums will require an episiotomy** is false. What these women need is a more patient physician. The unfortunate women who sustain sulcus tears are by and large women with poor tissue quality, apparently based on long-standing nutritional and constitutional factors. The role of the physician in preventing such trauma in these unfortunate women is limited. The opportunity to prevent perineal trauma in other, both exercising and non-exercising women, is great. The principle means of such prevention is the avoidance of routine episiotomy.

Yours sincerely,
Michael C. Klein, MD.

RE: TOXIC MEGACOLON IN PREGNANCY: A CASE REPORT. J SOC OBSTET GYNAECOL CAN 1998; 20(1): 74-7.

TO THE EDITOR:

I read this article with great interest, especially as the mother was a teenager. As a paediatrician, I was surprised that the abstract referred to the delivery 'of a near-term child,' when this child was born at 25 weeks. I don't think even my neonatologist colleagues would define this as near-term. Perhaps 'delivery of a viable infant' would have been more accurate.

Yours sincerely,
Miriam Kaufman, BScN, MD, FRCPC,
Associate Professor,
Department of Paediatrics, University of Toronto,
Staff Physician, The Hospital for Sick Children,
Toronto, Ontario.

DR. BELIVEAU REPLIES.

TO THE EDITOR:

Thank you for the opportunity to reply to Dr. Kaufman concerning the article which we published entitled "Toxic megacolon in pregnancy: a case report."

In the case report, we presented a pregnant young female who survived a major abdominal catastrophe leading to a total colectomy and its attendant complications to deliver a viable child a few weeks later. We agree with Dr. Kaufman that a child born at 25 weeks should be referred to as preterm in regards to gestational age, and in most cases, this corresponds to prematurity in developmental stages. I agree that near-term would apply to a birth between 34 and 37 weeks approximately, and that Dr. Kaufman is entirely correct in pointing this out to us.

Yours sincerely,
Paul Belliveau, MD.

RE: BACTERIAL VAGINOSIS. COMMITTEE OPINION. SOGC CLINICAL PRACTICE GUIDELINES. J SOC OBSTET GYNAECOL CAN 1997;19(5):527-36.

TO THE EDITOR:

The treatment of bacterial vaginosis in pregnancy is seen as controversial. Recent SOGC guidelines recommend the screening of pregnant women with a previous preterm delivery for bacterial vaginosis and treatment with metronidazole if the test is positive.[1] We recently reviewed the evidence for treating bacterial vaginosis in pregnancy, and found that the research on which this guideline is based may be flawed.

The guideline appears to be primarily based on the results of one randomized study.[2] This study reports a 50 percent reduction in preterm birth in patients with a