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

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history of prematurity when bacterial vaginosis is treated with oral metronidazole. However, while 94 patients were initially randomized to metronidazole or placebo, 14 patients were lost to follow-up, failed to finish their assigned treatment or required treatment with other antibiotics. Thus, the analysis was based on 80 patients. Others have cautioned that in cases where there has been loss of patients to follow-up, a check of the validity of the findings can be done by assuming that all patients in the intervention group not accounted for did universally poorly and those unaccounted for in the control group all did well.[3] If the conclusions are unchanged, then one can have more confidence in the findings. It is interesting that in the published discussion following the study, one of the discussants recommends that this be done.[2]

The table below includes the data from the original paper and a re-analysis subject to the above 'test.' Had all 94 patients been accounted for, and assuming an equal randomization, there would have been 47 in the treatment group (44 reported on) and 47 in the control group (36 reported on). The re-analysis assumes that the three unaccounted for women in the metronidazole group had the events that were to be averted. In the control group, the 11 unaccounted for women are assumed not to have had these events.

When the study is re-analysed accounting for losses to follow-up, the most important outcomes of preterm delivery and low birth weight are no longer significant. Thus, the study's conclusions fail this test of robustness. This raises concerns about the validity of the recommended clinical practice guideline. Such a guideline is likely to be influential in determining clinical practice, given the SOGC's credibility with practising physicians. Although we are all committed to reducing the incidence of preterm birth, we would suggest that the current evidence is not strong enough to support the position taken by the SOGC at this time, and that a re-evaluation of the guideline recommendation may be warranted.

TABLE 1

| Outcome | Original Report | | | Re-analysis | | |
|---|---|---|---|---|---|---|
| | Rx (n=44) | Control (n=36) | p | Rx (n=47) | Control (n=47) | p |
| Hospital admission for preterm labour | 12 | 28 | <0.05 | 15 | 28 | <0.05 |
| >1 | – | 10 | <0.05 | 3 | 10 | 0.07* |
| GA at delivery | | | | | | |
| <34 weeks | 2 | 4 | NS | 5 | 4 | NS |
| <37 wks | 8 | 16 | <0.05 | 11 | 16 | 0.25 |
| BW <2,500 gms | 6 | 12 | <0.05 | 9 | 12 | 0.46 |
| PROM | 2 | 12 | <0.05 | 5 | 12 | 0.06 |

*Fisher's exact test.

Yours sincerely,

W. McIsaac, MD, MSc, CCFP,
N. Suchak, MD,
A. Biringer, MD, CCFP,
Mt. Sinai Family Medicine Centre,
Mt. Sinai Hospital, Toronto, Ontario.

## REFERENCES

1. Bacterial Vaginosis. Committee Opinion. SOGC Clinical Practice Guidelines. J Soc Obstet Gynaecol Can 1997;19(5):527-36.
2. Morales WJ, Schorr S, Albritton J. Effect of metronidazole in patients with preterm birth in preceding pregnancy and bacterial vaginosis: a placebo-controlled, double-blind study. Am J Obstet Gynecol 1994;171:345-9.
3. Guyatt GH, Sackett DL, Cook DJ. Users' guide to the medical literature.II. How to use an article about therapy or prevention. A. Are the results of the study valid? JAMA 1993;270:2598-601.

### On behalf of the SOGC Committee on Bacterial Vaginosis, Dr. Bouchard Replies.

To the Editor:

We read with great interest comments from the group at Mt. Sinai Family Medicine Centre in Toronto, about the SOGC guidelines on Bacterial Vaginosis (BV), and are very pleased that our recommendations are being scrutinized so thoroughly.

The Toronto group questions the recommendation of the SOGC Committee based on Morales' study about screening for BV in high-risk pregnant women. They suggest that the results of that study did not meet one essential characteristic that guarantees the study to be acceptable for quality in controlled trials. Based on the recommendation of Guyatt *et al.*[1] in, "Users Guide to the Medical Literature," they reject without appeal the conclusions from Morales' study. After their own re-analysis, assuming an hypothetic worst case scenario for the fourteen missing patients, they obtained new results which are not statistically significant. The committee does not believe that, on the basis of re-analysis using Guyatt's recommendation, the Guideline should be changed. We wish to explain why.