

**“A STEPWISE APPROACH TO CERVICAL CERCLAGE”**

KATRIN KARL, MD; MICHAEL KATZ, MD  
(JUNE 2012)

**Confused by cover illustration of cerclage**

I keep looking at the illustration on the cover of the June issue to try to identify the anatomic elements grasped by the clamps. Is this a view into the vagina looking at the external os, and the cervix is grasped to place the cerclage—what anatomic landmarks are those? Am I confused or just ignorant?

Federico G. Mariona, MD  
Dearborn, Michigan

**>> Dr. Katz responds**

**Illustration shows clamped epithelium in cerclage from an unusual position**

I am delighted to hear from Dr. Mariona, and can assure him that he is NOT ignorant. I can very easily understand how the artist's rendering illustrating the cervical cerclage article could possibly cause confusion. My apologies.



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Dr. Mariona is probably wondering about those “appendages” on both sides of the Allis clamps. The “appendages” are formed when the clamps cinch the epithelial tissue on either side of the cervix.

Using a silicone model, I have

 \*To watch the video called “Clamping epithelial tissue in cerclage,” visit [obgmanagement.com](http://obgmanagement.com) and click on **Comment & Controversy**.

created a short **VIDEO\*** to show how this has come about. The model, which I use for teaching, has the following features: a blue line on top to delineate the cervico-vesical plica, a pink colored core (stroma), and a soft tissue covering the stroma representing the cervical epithelium or mucosa. In my model, the epithelium is only 2–3 mm thick all around; in some patients, it is well above 5–10 mm thick and wider than the cervical stroma by far.

**FIGURE 1** provides two photographs of how the clamped epithelium appears from different angles before and after tying the knot. The angle you see in the June cover illustration is simply looking at it straight from the front—a little unusual and potentially confusing.

**FIGURE 2**, which was deleted from the original article because of space limitations, also gives a good perspective from the top.

The article discusses clamping the soft tissue covering the cervical core or stroma in Step 5 and Figure 6 on page 35.

**FIGURE 1 “Appendages” formed by clamped epithelial tissue**



Both sets of Allis clamps have been placed on a silicone model, creating an “appendage” of epithelial tissue on both sides of the cervix. (A) is a view from the side of the cerclage; (B) from the top and front. The model has a blue line on top to delineate the cervico-vesical plica, a pink-colored core or stroma, and a soft tissue covering that represents the cervical epithelium or mucosa.

**FIGURE 2 Clamping the cervical epithelium**



Using bilateral Allis clamps, the soft tissue covering the core (stroma) is clamped between the cervico-vesical junction anteriorly and the superior point of the posterior fornix, posteriorly. This cardinal step separates the core from the mucosal/submucosal elements.

PHOTOGRAPHS COURTESY OF MICHAEL KATZ, MD  
ILLUSTRATION COURTESY OF JESSICA MAYER

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**“DOES ELIMINATION OF THE BLADDER FLAP FROM CESAREAN DELIVERY INCREASE THE RISK OF COMPLICATIONS?”**

BAHA M. SIBAI, MD (JUNE 2012)

**Making the incision well above the bladder reflection is crucial**

I don't think trying to decide whether to create a bladder flap or not is the issue. Making the uterine incision well above the bladder reflection is what's important.

A more useful study is to compare bladder injury and/or time of procedure in patients who have the bladder flap closed (usually above the uterine scar). It still makes no sense to me when I do repeat cesarean sections and find the bladder tacked up to the uterus, usually well above the prior closure. It's even a bigger problem in the event of a dehiscence, when the main chore is to safely peel away the bladder from “tissue paper” uterine wall to ensure proper uterine closure.

Better yet, STOP closing the bladder flap.

**Miguel A. Cano, MD**  
Reedley, California

**“BE ACTIVE, NOT PASSIVE, WITH HOW YOU SCREEN FOR TYPE 2 DIABETES”**

ROBERT L. BARBIERI, MD  
(EDITORIAL, JUNE 2012)

**I agree—We need to aggressively test for diabetes and lipids**

I wish to commend Dr. Barbieri for his excellent discussion and recommendations for diabetic screening.

With occasional exceptions, I order a hemoglobin A<sub>1c</sub> (HbA<sub>1c</sub>) test on every patient at the time of her annual exam. If the HbA<sub>1c</sub> concentration is 5.7 or greater, I explain that she is officially “prediabetic” and needs to understand what that means.

If the HbA<sub>1c</sub> is between 6.0 and



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6.5, I order a 2-hour glucose tolerance test with insulin levels. This testing picks up a large number of women with impaired fasting glucose and impaired glucose tolerance. Some will have a normal glucose tolerance test, but their insulin levels will demonstrate significant insulin resistance. All these women need to be treated with metformin, which will significantly reduce their likelihood of becoming diabetic. I also discuss and advocate lifestyle modification, but this counseling usually does not translate to a substantial change in patients' prediabetic conditions—which is why the metformin is necessary.

These patients also need a complete evaluation of their lipid status. The standard lipid profile ordered by most physicians is not accurate enough in today's world. A vertical auto profile (VAP), which gives much more information about a patient's lipid status, should be done because many of these patients already have significant dyslipidemia.

Although the American Diabetes Association states that an HbA<sub>1c</sub> greater than 6.5 is diagnostic of

diabetes, there are occasional patients in the 6.5 to 7 range who are not diabetic and these people also should have a glucose tolerance test. Anyone with an HbA<sub>1c</sub> of 7 or greater should be considered diabetic without additional testing.

I fully agree that we need to be very aggressive in looking for these problems so that we can prevent the serious complications associated with uncontrolled diabetes.

**Michael D. Birnbaum, MD**  
Elkins Park, Pennsylvania

**“LAY MIDWIVES AND THE OBGYN: IS COLLABORATION RISKY?”**

LUCIA DIVENERE, MA (MAY 2012)

**L&D without support facility and trained personnel is irresponsible**

Is collaboration too risky? The answer is **absolutely!** An OB would have to be crazy to lend his or her name or back-up to a midwife working outside the hospital setting.

Assisting women in labor and delivery without support facilities and trained personnel at hand is irresponsible. Every practicing OB knows that, even in the most “routine” labor, things can go very bad very quickly. The ability to immediately intervene has saved countless lives.

In addition, I cannot believe any medical liability insurance provider would agree to cover an OB who is involved with deliveries outside a hospital setting. Add that some midwives are so poorly trained, and the multiple dangers are intensified.

Who would want to voluntarily carry that burden of the death of a child or mother for the rest of their lives?

To those physicians who do want to stick their necks out and agree to provide back up: keep in mind that, when a lawsuit comes, the deep

pockets are not with the midwife, but with you.

**James P. Haley, MD**  
Rome, Georgia

**“STOP PERFORMING MEDIAN EPISIOTOMY”**

ROBERT L. BARBIERI, MD  
(EDITORIAL; APRIL 2012)

**Do what you’re comfortable doing, based on your experience and dexterity**

I have to disagree with Dr. Barbieri’s recommendation to start using a mediolateral episiotomy. I read the comparisons from the studies mentioned—all good, sound data—but from a personal point of view, from a physician who has been in practice more than 19 years, and from one who has done both mediolateral and median episiotomies, I find it far easier to repair the median type.

I have had very few complications of breakdown, infection plus breakdown, or poor sphincter control with median episiotomies. In fact, my incidence of the above complications is close to nill, and my frequency of third- and fourth-degree tears is low. I know how to repair third- and fourth-degree tears, and you still can get one of these tears with a mediolateral episiotomy. It also depends on the physician performing delivery and whether or not they know how to support the perineum in the second stage, to reduce tearing in general.



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I get consults from patients who have had mediolateral repairs elsewhere, and they suffer an increased incidence of marked vaginal asymmetry (one side higher than the other). For these patients, I perform vaginoplasties and vaginal tightening. I have seen horrible results from a mediolateral repair, one of which developed necrotizing fasciitis. There is also concern about scarring: Dr. Barbieri’s Editorial mentioned that the median incision group had “good” appearance (43%) compared with 27% in the mediolateral group. (I know I’m cherry picking data now.)

My point is that recommending mediolateral episiotomy across the board may cause more morbidity,

especially in the hands of someone who doesn’t know how to make a good repair.

The pearl on page 10 is good. However, I think that the physician should do what he or she is comfortable doing, based on his or her experience and surgical dexterity. I shall continue to use the median episiotomy as my “go to” procedure.

**Marcus D. Barnett, MD**  
Houston, Texas

**>> Dr. Barbieri responds**  
**Consider occasionally trying mediolateral episiotomy?**

*I deeply respect the clinical experience and insights of Dr. Barnett. I understand that he has concluded that the benefits of median episiotomy are superior to mediolateral episiotomy, and I encourage him to continue performing median episiotomy. I wonder if he would consider occasionally performing mediolateral episiotomy when doing an operative vaginal delivery?*

*A recent article concluded that when performing an operative vaginal delivery, a mediolateral episiotomy was associated with a 6-fold decreased odds for developing an obstetrical anal sphincter injury compared with a median episiotomy.<sup>1</sup>*

**Reference**

1. De Vogel J, van der Leeuw-van Beek A, Gietelink D, et al. The effect of a mediolateral episiotomy during operative vaginal delivery on the risk of developing obstetrical anal sphincter injuries. *Am J Obstet Gynecol.* 2012;206(5):404.e1-e5.