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Note: The authors of the main article and accompanying mini-commentary were invited to respond to this letter but declined to do so.
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Authors’ reply

Sir,

We wish to thank Matsubara et al. for their comments relating to our article.1,2 We agree wholeheartedly that risk needs to be communicated to the patient and her partner whether she is undergoing surgery for AIP or undergoing pregnancy with underlying complex maternal heart disease. A recent UK ruling from the Supreme Court has brought this to the forefront and clearly demonstrates that we can no longer practise medicine in a paternalistic fashion.1 All the authors of our paper have had individual experience counselling women undergoing very high-risk pregnancies, and we feel that women must be provided with clear, accurate information that includes all aspects, even when that might cause anxiety. Nothing less than this is acceptable. Ultimately, whatever our personal choices would be, it is the prerogative of the woman to decide her future, and she must then be supported positively no matter what decision she decides to make.4 Occasionally this will lead to maternal mortality but it is not for the attending doctor to make value judgments about an individual woman’s own decisions. Working in highly collaborative multi-disciplinary teams helps to ensure that the management of these challenging cases is in line with best international standards, and the psychological burden to the individual of managing such cases is reduced by being shared. We are reminded by a recent high profile case in the UK that maternal death from obstetric haemorrhage still continues, and will do so despite the best interventions from medical staff.3 Nevertheless, we appreciate that the media and society often look to apportion blame even when the judicial ruling is that there is none to be allocated. We must therefore make every effort to support staff who are ‘caught up’ in such circumstances so that they themselves do not become victims.

References

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Re: Use of a postoperative pad test to identify continence status in women after obstetric vesicovaginal fistula repair: a prospective cohort study

Sir,

We read with interest the article ‘Use of a postoperative pad test to identify continence status in women after obstetric vesicovaginal fistula repair: a prospective cohort study,’ and it generated good debate in our hospital Journal Club. Ensuring appropriate follow-up after fistula repair is clearly challenging in a low-resource setting, and the authors’ efforts to utilise a simple, low-cost tool to predict outcome and enable targeting of resources should be commended. However, there appear to be limitations in the methodology of the study that require further exploration.

Use of a control group of subjects of similar ages and parity but without fistulae could have effectively identified an appropriate cut-off for positive pad tests, as those set by the International Continence Society may not have been relevant to this patient population. Additionally, there is insufficient information about the conditions under which the pad test was performed. There is a significant risk of these patients developing urinary tract infection, but there is no evidence that this was tested for. It is also not known whether patients’ fluid balance status was monitored, or what activities were carried out while the pad was in situ. All of these factors would affect the pad weights obtained.

It was noted that the patients underwent cough stress tests prior to discharge, but there was no comment on how the results of these correlated with the follow-up findings. This simple and rapid test that produces objective, binary results could easily have been incorporated into the statistical analysis, and might have produced an improvement in sensitivity or specificity in conjunction with the pad test.
Continence at follow-up was assessed by patient self-reporting, which has a high risk of bias. It seems inconsistent to record objective data on pad weight prior to discharge but follow patients up using subjective methods. As the authors acknowledge, urodynamic testing would provide evidence of the severity and nature of residual incontinence. If subjective scoring is to be undertaken, acceptability of residual incontinence and quality of life measures would seem more relevant than the continence grading system used.

Overall, this paper certainly highlighted the challenges faced by clinicians trying to improve long-term post-operative outcomes in this unique population of patients, and will hopefully act as a foundation for further research in the area.

Reference


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Authors’ reply

Sir,

We thank the participants of the Bedford Hospital Journal Club for their interest in our paper and the expressed concerns.

We appreciate the idea to alter the study design with the use of a control group of subjects of similar ages and parity but without fistulae to determine a normative/negative value for the 1-hour pad test. As this was not a part of the study design, we instead relied upon the upper limit recommended by the International Continence Society and explored thresholds of 1 and 2 g, chosen for other studies on women with urinary incontinence.

The 1-hour pad test was conducted among patients who had a negative dye test and they were instructed to wear it for 1 hour with usual activities. All patients were fully ambulatory. We acknowledge there is a significant risk of urinary tract infection in women after fistula repair. Symptomatic women are tested with a urinalysis and treated if suspicious for infection, but urine culture is not available in this setting. Fluid status is monitored initially after surgery, but is not strictly controlled during the 1-hour pad test, which may affect the results. Additionally, we acknowledge that the pad test occurs soon after the Foley catheter is removed, which may not allow the women to adequately acclimate to being without the catheter prior to testing.

We realize that further statistical analysis of these data could take into account the results of the cough stress test in an evaluation of the association with the 1-hour pad test result and continence status within 120 days of vesicovaginal fistula (VVF) repair. However, our goal of this analysis was to examine the utility of a simple, readily available objective clinical result that could be quickly evaluated in a resource-limited setting. A range of factors that affect the risk of residual incontinence was evaluated in a separate analysis published by our group.

We acknowledge that the outcome of continence grade at follow-up is not objective. Quality of life measurements have been utilized alongside 1-hour pad tests in a recent study evaluating continence of women in the years after VVF repair (currently being analysed), as we recognize that the same amount of urinary leakage may be accepted differently among women.

References


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Re: Variations in very preterm birth rates in 30 high-income countries: are valid international comparisons possible using routine data?

Croatian experience supporting inclusion of routine very preterm birth data for valid comparison