The case for "culdolaparoscopy"

TO THE EDITOR:

I read with interest Dr. Eric J. Bieber's March 2004 article ("Laparoscopic tissue extraction: Pros and cons of 4 techniques") and agree that most surgeons extract tissue through abdominal ports, which is the simplest technique.

However, I sometimes utilize a vaginal port to aid in laparoscopy as well as minilaparoscopy; I refer to this procedure as "culdolaparoscopy." This multifunctional vaginal port can be used for insufflation, visualization, operation, and extraction of the specimen.[1,2] The technique can be performed when there is easy access to the posterior vaginal fornix with no obliteration of the posterior cul-de-sac.

As for the difficulty of using a posterior colpotomy to remove more than 1 specimen, different techniques that address those disadvantages have been described.[3,4] Dr. Bieber also expressed concern about subsequent adhesion formation, but colpotomy yields good cosmetic results and decreases the risk of incisional hernias, and a literature review and multicenter study suggests it is safe.[4]

In my experience, there are fewer candidates for colpotomy or culdolaparoscopy than for the use of abdominal ports. However, I recommend a vaginal approach when it is possible and appropriate, as it allows the removal of large specimens while using abdominal ports no more than 3 mm or 5 mm in diameter.

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VBAC: Let's end the semantic games

TO THE EDITOR:

Although I appreciated the April article on VBAC by Drs. Thomas D. Shipp, MD, and John T. Repke, MD ("Preserving the VBAC alternative: 8 pearls"), it failed to address the real reason VBAC is declining—at least in smaller hospitals.

At my rural hospital, both my liability insurer and the facility's insurer decided it was no longer acceptable for the anesthesiologist and operating room team to be available within 15 minutes. Instead, they must remain physically "in house" along with the pediatrician and obstetrician during the entire duration of the patient's labor.

This did not present a problem for me, as I have been in the habit of staying in the hospital for these patients all along, but it essentially ended the ability of the hospital to offer this service. A small rural hospital such as mine does not have sufficient numbers of personnel to ask them to sit in the hospital for 8 to 12 hours—sometimes longer—for what may turn out to be a successful vaginal delivery.

While the change in policy has certainly not impacted my lifestyle negatively (it is always easier to come in and do a repeat

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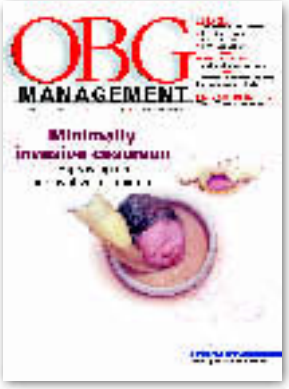
cesarean than to sit with a patient through a long trial of labor), the people it certainly hurts are the women in my community. These women now are asked to make a choice between travel to the nearest large urban center (1-1/2 to 2 hours away by private vehicle), an unwanted major surgery, or a home birth with one of our local lay midwives, who are happy to labor these patients in birthing centers and private homes an hour away from emergency cesarean services.

In essence, we have taken 1 obstetric emergency (uterine rupture) and singled it out for a different standard of care. The same requirements for in-house personnel are not in place for the rest of our obstetric patients, who may come in with cord prolapse, abruption, severe hemorrhage, or fetal distress at any time—all of which mandate emergency cesarean.



If we as a profession want all the women of the United States to receive high-quality obstetric care, we should ask the American College of Obstetricians and Gynecologists to support the 30-minute "decision-to-incision" rule and stop playing semantic games with phrases such as "readily available" and "immediately available." Our counterparts in the legal profession and insurance industry have used these phrases to insist on an impossible standard of obstetric care for rural America, effectively driving many patients into the arms of rural lay midwives, sometimes with disastrous consequences.

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Where's the data on minimally invasive cesarean?

TO THE EDITOR:

I was greatly troubled by your publication of the article on "minimally invasive" cesarean by Drs. Marco A. Pelosi II and Marco A. Pelosi III ("Minimally invasive cesarean: Improving an innovative technique," July). The technique described is neither innovative nor improved. The authors describe standard cesarean technique with the addition of a disposable "surgical device" previously used for their so-called hand-assisted laparoscopy. They offer no proof of safety or efficacy and no proof that the technique improves fetal or maternal outcome.

I hope the fact that your journal is not peer-reviewed does not absolve you from any editorial control.

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DRS. PELOSI AND PELOSI RESPOND: The confrontational nature of Dr. Janicki's letter makes it obvious he has not seen or performed the cesarean procedure described and hasn't bothered to read the article carefully or review the literature on the subject.

As for hand-assisted laparoscopy, we would like to remind Dr. Janicki that it has become the technique of choice for a large number of minimally invasive surgeons who use it to perform splenectomy, nephrectomy, bowel resection, and bariatric surgery. The peer-reviewed literature on hand-assisted laparoscopy, including ours, is quite extensive. ■