



BJOG Exchange

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Authors' reply

Sir,

Birth Trauma organizations advocate on behalf of women and babies who have experienced adverse outcomes, and naturally, they will take a risk-averse perspective on birth-related care. The latest version of the Assisted Vaginal Birth (AVB) RCOG Guideline (previously called Operative Vaginal Delivery) has focused specifically on revisions designed to minimize the risk of traumatic injuries for the mother and baby.¹ The landmark Montgomery ruling that raised the bar on the standard required for informed consent has been embraced and endorsed within the guideline.² It is disappointing to read that Hull *et al.*³ have concluded that 'Montgomery is missing from RCOG's Assisted Vaginal Birth guideline'.

Hull *et al.* have acknowledged the important counselling advice that has been recommended – antenatal discussion about AVB when planning birth in the third trimester (especially for first-time mothers), review of birth preferences when conducting routine labour ward rounds, and in-depth counselling, where circumstances allow, if complications arise during the course of labour, particularly during the second stage. However, the guideline apparently falls short of the Montgomery ruling in that we have not recommended 'planned caesarean' as an option to prevent assisted vaginal birth.

The AVB guideline went through an extensive scoping process. The agreed scope was to address all key questions that arise in relation to labouring

women who may require obstetric assistance in the second stage of labour – the assumption being that these women have the intention to labour and deliver vaginally. A guideline addressing maternal request 'planned' caesarean section is an entirely different guideline. It is also incorrect to state that the RCOG has provided no direct guidance on this (see *Choosing to have a Caesarean section*, RCOG Patient Information (2015) based on NICE Clinical Guideline *Caesarean Section* (2011)).⁴ The issue of pelvic floor morbidity was included in the literature search and has been discussed in detail.

The Montgomery ruling related to a woman with diabetes in pregnancy and a large-for-gestational-age fetus who experienced shoulder dystocia, resulting in her baby developing cerebral palsy. The importance of outlining, in advance, the birth options for this woman is clear, given the specific known risks associated with labour in her circumstances. Hull *et al.*, suggest on the same basis that all women should be advised that a planned caesarean section is an option to prevent assisted vaginal birth. If taken one step further, the Montgomery ruling could be cited to support the argument that all women should be advised that the best way to avoid pregnancy-related complications is to avoid getting pregnant. Common sense would infer that this was not the intention of the Montgomery ruling.

Where this RCOG guideline is likely to be consistent with Birth Trauma organizations is in the recommendations on careful assessment, supervision and decision-making; clear communication and transparent consent procedures; and an overall approach that places safety as the first priority when deciding when and when not to attempt a vacuum or forceps assisted delivery, and when to discontinue any such attempt. It is hoped that all relevant health professionals will review and implement the evidence-based, peer-reviewed recommendations within this guideline. They are designed to support women in achieving safe and

joyful births, even when obstetric assistance is required. ■

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Do pregnant women have protective immunity against COVID-19?

Sir,

The current epidemic caused by the highly contagious severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) and its rapid spread globally is of major concern. Pregnant women could constitute a vulnerable population.

We read with interest the article *COVID-19 in pregnancy* by Jim G. Thornton, in which the author relates that coronavirus disease 2019 (COVID-19) is less severe in pregnancy than the two previous coronavirus infections, SARS and Middle East respiratory syndrome.¹ We fully agree with the author and would like to make some assumptions for a less frequent and severe disease in pregnancy.

Lower rates of SARS-CoV-2 among pregnant women have been reported in different surveys published around the world (USA, China, Italy) and is probably due to several factors: pregnant women are younger and therefore are less likely to have typical symptoms; but are also admitted usually for labour and delivery and not because of SARS-CoV-2 symptoms, so are less tested.

Furthermore, as SARS-CoV-2 infection can activate innate and adaptive immune responses with severe consequences, pregnant women could be preserved by the state of immunomodulation during pregnancy.

In pregnancy, progesterone has immunomodulatory properties allowing maternal tolerance of the fetus and so can impact many immune pathways involved in autoimmune disease and immune-mediated injury.² During pregnancy, there are increased circulating levels of anti-inflammatory molecules interleukin-1 receptor antagonist (IL-1RA) and soluble tumour necrosis factor- α receptor (TNF-R), along with decreased IL-1 β and TNF- α .² Autoimmune diseases like rheumatoid arthritis and multiple sclerosis remit during pregnancy.



In the most severe SARS-CoV-2 infections we report uncontrolled inflammatory innate responses and impaired adaptive immune responses that may lead to harmful tissue damage, both locally and systemically. Progression to acute respiratory distress syndrome is associated with the increase of pro-inflammatory cytokines and chemokines, known as cytokine release syndrome.³ A cytokine profile has been reported in most severe SARS-CoV-2 infections, characterised by increased levels of cytokines and chemokines.

In a systematic review of the available literature including six studies with 51 pregnant women,⁴ the outcome has been generally favourable for both mothers and fetuses. In their review, women have been most often delivered by caesarean section, and frequently before term gestation. As in patients infected with SARS-CoV-2, the serious complication is acute

respiratory distress syndrome and ventilation of the mother may be difficult in the third trimester of pregnancy; it is certainly possible that the decision to delivery by an elective caesarean section was influenced by the understandable anxiety towards the potential consequences. ■

References

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Re: Mirena Coil is a suitable treatment of early stage endometrial cancer in obese women: FOR or AGAINST?

Sir,

We read with a great deal of interest the articles presenting pros and cons of Mirena Coil use in the management of early stage endometrial cancer in obese women by Farthing and Barr which were recently published in your journal.^{1,2} We agree that surgical management in such patients may become a challenge due to

comorbidities and difficulties in the surgical field, including inadequate exposure because of adhesions/visceral adiposity and/or intolerance of the Trendelenburg position.

Dr Barr and Professor Crosbie highlight the absence of randomised controlled trials comparing progestin treatment and examining route, duration and dose with hysterectomy in morbidly obese patients. We are awaiting with a great deal of interest the results of the feMMe trial which recruited 165 patients at 15 sites throughout Australia and New Zealand.³ The primary aim of this study is to evaluate the efficacy of the Mirena Coil, with or without metformin, and with or without weight loss in order to achieve a pathological complete response in morbidly obese patients with endometrial cancer at 6 months from study treatment initiation.

We agree with Mr Farthing that such patients should be treated surgically in tertiary centres by experts using a minimal invasive approach. We would like to add and highlight that in a recent metanalysis, robotic and laparoscopic hysterectomy were found to have similar perioperative complications (organ/vessel injury, venous thromboembolism, blood transfusion) in such patients; however, robotic hysterectomy had lower conversion rates in patients with morbid obesity, which is crucial for the enhanced recovery and safety of each such individual patient as well as the total cost in each health system.⁴

To date, Mirena coil use could considered an alternative option for 'carefully selected, adequately counselled and motivated to undergo the requisite intensive endometrial surveillance' only in well-organised trials in combination with other approaches, e.g. weight loss +/- bariatric surgery if necessary. Further future, strictly organised multicentre randomised trials could be considered and could probably overcome the retrospective character of single-centre findings. ■