

Letters

Laparoscopic removal of abdominal cervical suture

Editor,

Cervical incompetence is diagnosed in 0.1-1% of all pregnancies and in 8% of women with repeated (two or more) mid-trimester pregnancy loss.¹ Cervical cerclage should be offered to patients with three or more pregnancies ending before 37 weeks gestation² as there is a strong body of clinical evidence suggesting that cervical cerclage decreases the occurrence of mid-trimester pregnancy loss. Sutures may be placed abdominally or, more commonly, vaginally in the cervix. The most common indications for trans-abdominal insertion of a cervical cerclage are congenital or acquired shortening of the cervix preventing application of a cervical suture and failed vaginal suture.

Case Report: A 42 year old para 1⁺ was seen at the gynaecology clinic complaining of pelvic pain and requesting sterilisation. Historically, following two mid trimester pregnancy losses, a vaginal cervical suture was placed but a subsequent pregnancy miscarried at 23 weeks. An abdominal cervical suture (polyethylene terephthalate, polyester tape) was inserted in the patient's third pregnancy at 11 weeks gestation. This pregnancy proceeded to term, when a healthy female infant was delivered by Caesarean section. One further subsequent pregnancy in 2002 resulted blighted ovum at 10 weeks gestation. Following discussion about laparoscopic sterilisation, the possible cause for pain and the risk of suture erosion the decision was taken to perform a laparoscopic sterilisation and removal of cervical suture.

A three port laparoscopy was performed and the knot of the suture was identified posteriorly but was buried in peritoneum and could not initially be cut. The knot was freed and the suture was cut using laparoscopic shears. The suture was then easily 'pulled through' and removed via the port in the left iliac fossa. A 1/8 inch Portovac drain was left in the pelvis. A single Filshie clip was applied to each tube, the gas evacuated from the abdomen and the abdominal wounds closed with polydioxanone (PDS). Operating time was 23 minutes. The postoperative course was unremarkable and the patient was fit for discharge when the drain was removed the following morning.

Cervical sutures are increasingly being inserted laparoscopically. Numerous reports claim that the procedure is safe and has advantages over the open method.³ There is mixed opinion however as to the optimal position of the suture knot. One theory is that by tying the knot posteriorly, one is less likely to have dense fibrous adhesions and therefore facilitate its straightforward subsequent removal via the Pouch of Douglas.

Cases of laparoscopic removal of abdominal suture are rare, indeed only two cases have been published. Both cases had had a suture applied only 5-7 weeks prior to its removal, and the indication for removal in both was to facilitate evacuation of retained products of conception following the diagnosis of

fetal demise. In one case only a partial suture removal was possible due to the presence of fibrous adhesions.

The decision to attempt removal of the suture in this case was based on the patient's increasing pain over the previous six years, combined with the reported risk of erosion associated with leaving the suture in-situ.³ Laparoscopic removal was chosen as the method primarily because the patient requested laparoscopic sterilisation and thus an opportune time to retrieve the suture presented itself. The peri-operative and long-term benefits as mentioned above were also considered.

In a unit with skilled laparoscopic surgeons and high-risk obstetricians, the potential for laparoscopic insertion and removal of abdominal cervical sutures exists. However, data regarding issues such as optimum technique, safety, feasibility and outcomes is currently lacking. These deficiencies need to be addressed prior to the acceptance of this procedure as standard.

The authors have no conflict of interest

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The TG system for bedside recording of sputum colour

Editor,

Most people will know that during a lower respiratory tract infection the sputum is usually discoloured. Typically it is a darker green in the early stages and gradually lightens as the infection improves with time and treatment. The green colour is due to the presence of myeloperoxidase, an enzyme found in neutrophils. The greenness of the sputum, assessed using a commercially available nine point colour chart (BronkoTest UK),¹ has been shown to correlate with sputum bacterial counts,² and with sputum leukocyte elastase, interleukin-8, and proteinase inhibitor levels.³

Those with experience of treating exacerbations of chronic