



Editorial

An easy method to define the cervical borders during postpartum hysterectomy



Obstetric hemorrhage is frequently noted in routine clinical obstetric practice and also a main cause of maternal death in the world, although the incidence of major obstetric hemorrhage-inducing maternal death is extremely low in Western countries, including Taiwan.¹ There are some reasons to respond to the discrepancy between the frequent occurrence of obstetric hemorrhage (a worldwide prevalence of 6%) and rare subsequent maternal death presents (less than 0.1%), including an early identification of risk factors associated with obstetric hemorrhage (placental previa, placenta accreta and uterine atony), and an early intervention and prompt management of obstetric hemorrhage (massage, the use of carbetocin, and so on) and of most of importance, a more effective therapy available, including improvements in anesthesia, medicine, surgery, and even radiology for obstetric hemorrhage.^{2–7} Among these, uterine artery and/or internal iliac artery occlusion by ligation or embolization and peripartum hysterectomy is considered one of the most emergent life-saving procedures in cases of intractable obstetric hemorrhage.^{1,8–10} As mentioned in this issue published in the *Journal of Chinese Medical Association* by Dogan et al.,¹¹ although the technique for peripartum hysterectomy is very similar to the abdominal hysterectomy, there is no doubt that peripartum hysterectomy holds specific surgical challenges because of physiological and anatomical changes that occur during pregnancy, especially for those women who have labored at full dilatation of the cervix.¹¹ Therefore, it is very important to further improve the surgical technique to perform peripartum hysterectomy and further minimize the risk of incomplete removal, excessive loss of vaginal tissue and urinary tract injury (ureter and bladder) due to the loss of cervico-vaginal junction and the limited exposure cause by heavy bleeding.¹¹

The authors used two ring forceps to grasp the fully effaced cervix at the 6 o'clock and 12 o'clock positions via the vaginal approach in lithotomy position preoperatively and this technique can easily and clearly identify the boundaries of the cervix with full effacement and dilatation.¹¹ Then, the bladder and rectum were dissected off the lower end of the uterus and the operators can easily reach the previously placed clamps and determine the boundaries of the cervix and vagina.¹¹ The

authors used the above-mentioned technique to finish 4 peripartum emergency hysterectomy and investigate their sexual functions by the questionnaire of female sexual function index (FSFI) and finally got the following results: 27, 27, 30 and 31 of these women at the 6 months after operation, respectively.¹¹ The authors did not further explain the meaning of their FSFI scores in their study.¹¹ The FSFI assesses aspects of female sexual function in six areas: sexual desire, arousal, lubrication, orgasm, sexual satisfaction, and sexual pain.^{12,13} Individual domain scores on the FSFI range from 0 to 6, with a higher score indicating better sexual function and less pain, and a score of zero indicating no sexual activity during the previous four weeks.¹³ Wegel et al. had defined the sexual dysfunction, which had an FSFI total score of 26.55 or lower.¹³ Based on this criteria, sexual function in the Dogan et al.'s study¹¹ might be good, because these scores were higher than 26.55. However, is it representative? First, these full scores of the FSFI do not provide domain-specific cutoff points to assess the presence of sexual difficulty in individual domains.¹⁴ Second, the women might have a main problem of hypoactive sexual desire disorders but she was diagnosed as sexual dysfunction. The underlying causes of female hypoactive sexual desire disorders might be more complicated than those of other 5 items, such as arousal, lubrication, orgasm, sexual satisfaction, and sexual pain. Therefore, to claim that this technique for postpartum emergency hysterectomy might have benefits of postoperative sexual function should be more careful, since there is no reference (baseline) of the FSFI in the women who underwent peripartum hysterectomy for comparison.

Although sexual function after various kinds of gynecologic operations has been studied widely and previously,¹⁵ there is still absent of data addressing sexual function after peripartum emergency hysterectomy. For obstetric surgery, even though termination of pregnancy or sterilization, it is more difficult to evaluate the sexual function after surgery, because of their greater emotional impact.¹⁵ If it is true that many sexual problems are the result of poor preoperative explanation and postoperative instructions, hypothesized by Amias,¹⁵ the decision for peripartum emergency hysterectomy may not allow sufficient time for an adequate and unhurried explanation of the purpose and effects of the operation,

including the reassurance that any disturbance of function will be transient or minimal. Therefore, this simple and practical cervical clamp technique might help obstetricians to perform postpartum emergency hysterectomy, but evidence to benefit in sexual function might be scarce.

Conflicts of interest

The authors declare that they have no conflicts of interest related to the subject matter or materials discussed in this article.

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