

a case of uterine dehiscence that occurred at 19 weeks of gestation.<sup>2</sup> The etiology was a septic necrosis of the myometrium secondary to a laparoscopic myomectomy. The area, approximately 7 × 2 cm, of the amniotic sac was clearly visible. The edges of the defect were brought together with 3 slow absorption stitches of number 1 chromic. The remainder of the pregnancy was uneventful, and a healthy baby was born by elective cesarean delivery at 37 weeks of gestation. These 2 observations show that successful conclusion to the pregnancy is possible when uterine dehiscence has occurred, whatever the size or the term of its incident. Therefore, as regards medicolegal pressures, they provide to obstetricians further medical information to advise patients regarding continuation of pregnancy when uterine dehiscence occurs in very premature pregnancies. Moreover, this also emphasizes the need for close obstetric monitoring in patients with a previous medical history of laparoscopic myomectomy.

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#### *In Reply:*

I would like to thank Dr. Loïc Sentilhes et al for their interest in our article. Their experience supports the use of uterine repair for the continuation of the pregnancy in the very premature pregnancy with a uterine dehiscence.

I also strongly agree that “this also emphasizes the need for close obstetric monitoring in patients with a previous medical history of laparoscopic myomectomy.” In the last month, we had a uterine rupture at 33 weeks of gestational age that resulted in an emergency cesarean delivery and multiple blood transfusions. The patient had a prior laparoscopic myomectomy at the site of the uterine rupture. The laparoscopic myomectomy removed a large pedunculated myoma utilizing monopolar

cautery. Further investigation is required to determine whether laparoscopic myomectomy can be safely performed in patients considering future fertility.

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## Using an Electronic Medical Record to Improve Communication Within a Prenatal Care Network

#### *To the Editor:*

Dr. Bernstein et al<sup>1</sup> have provided a welcome addition to the sparse body of literature focusing on both obstetric communication problems and the potential benefits of electronic prenatal records in labor and delivery. That approximately 30% of the time no prenatal charts were available when laboring patients were admitted to labor and delivery is probably not surprising to most obstetricians and is similar to what we reported (Miller DW Jr, Yeast JD, Evans RL. The unavailability of prenatal records at hospital presentation. *Obstet Gynecol* 2003; 101:87S) when we found that prenatal records at a community hospital were missing 37% of the time on initial presentation to labor and delivery and that records were never available 20% of the time. Prenatal care is indeed an ideal clinical area for the implementation of electronic medical records for reasons<sup>2</sup> that were no doubt contemplated in the earliest of implementations.

However, Dr. Bernstein's concluding statement is reminiscent of interactions with *Obstetrics & Gynecology* reviewers I have had on similar topics. The statement “Future studies of this and similar information systems should begin to look at whether the benefits of these systems actually translate into evidence of improved health care outcomes for patients” sounds formulaic, as if it were inserted in deference to reviewers who habitually demand outcome studies, not just for new diagnostic or therapeutic modalities, but even for new information technologies. Considering that there have not been perinatal outcome studies to evaluate the effectiveness of other infrastructure advances like electricity, telephones, faxes, beepers, or plumbing, it may be unreasonable and perhaps unattainable to expect the rigor of Level A outcome evidence for technology that is so obviously helpful. This is especially true when the evidence is inconclusive that prenatal care itself improves perinatal outcomes.<sup>3</sup>



I wonder if Dr. Bernstein has any doubts that 100% availability of prenatal records in labor and delivery improves care? Would he ever recommend going back to paper records under any circumstances? Would he consider it even ethical to do the studies he has advocated in his concluding statement?

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#### *In Reply:*

We appreciate and welcome the comments of Dr. Miller concerning our paper<sup>1</sup> on utilizing a computerized prenatal record available across a network to improve communication between the outpatient office, the fetal testing units, and the labor suite. We do believe that having improved access to the prenatal record, as demonstrated in our study, will result in improved care. That does not guarantee, however, that the size of the benefit will outweigh its cost. Therefore, we stand behind our statement that future studies should explore whether the use of information systems such as the one we have described will translate into measurable improved patient outcomes. While we are not advocating randomized controlled trials of these technologies, retrospective case-control studies such as the one we conducted may provide sufficient evidence to support the increased utilization and financial support of these information technologies.

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## Training the Gynecologic Surgeon

#### *To the Editor:*

I have read with interest, and concern, the 2 excellent articles in the January 2005 issue of the *Green Journal*, one by Dr. Fenner<sup>1</sup> and the other by Drs. Rogers and Julian.<sup>2</sup>

Dr. Fenner states that a review of the last 10 years of data from the Residency Review Committee “shows that the mean number of surgical procedures has not changed.”<sup>1</sup> Later in her manuscript, she observes that “fewer gynecologic surgeries [are] being performed nationally . . .” Dr. Fenner also reports that the survey of Sorosky and Anderson,<sup>3</sup> presented to the Society of Gynecologic Oncologists and based on expert opinion, observed that “graduating residents were less prepared to provide preoperative, operative (surgical technique), and postoperative care than residents trained 5 years before.”

Drs. Rogers and Julian harken us back to the days when obstetrics and gynecology were separate disciplines, with gynecology falling under the purview of general surgery. Their recommendation of going to a 5-year program is not a new notion. The postgraduate year 1 would be a transitional year “supervised by primary care educators . . .”<sup>2</sup> In spite of the efforts of The American College of Obstetricians and Gynecologists to define our specialty as primary care doctors for women so that our patients would not be denied access by insurance carriers, ours is still a surgical specialty.

A review at our institution of the time periods 1999–2000 and 2003–2004 (postresident time restrictions) showed an increase in all gynecologic cases from 3,295 to 3,447. What is of interest, and concern, is that much of this increase occurs in the outpatient setting. What is compelling, however, is a comparison of the surgical experience of our chief residents during these same time periods, when the number of major gynecologic cases from 1999–2000 was 507 cases (~101/resident), compared with the 2003–2004 period of 283 cases (~57/resident). On the oncology service, as part of these totals, during the 1999–2000 period we did 333 majors, and from 2003–2004 there were 519 major gynecologic cases.

The primary variable that these bright young physicians are subject to is that of external requirements, most notably the time restriction of the 80-hour week and of the time limit of successive hours. Call me old fashioned, but no matter how many “labs/models” one does, it is not the same. One learns surgery by doing surgery; this

