



Correspondence

Cervical cerclage in twin pregnancies

Preterm delivery is still a big challenge in obstetrics and highly associated with maternal and neonatal mortality and morbidity [1–3], especially in twin pregnancies. In the July issue of the *Taiwanese Journal of Obstetrics and Gynecology*, we read with interest about the article entitled “Outcomes of ultrasound-indicated cerclage in twin pregnancies with a short cervical length” by Dr. Wu and colleagues [4]. Although whether to perform cervical cerclage in twin pregnancies with a short cervix is still controversial, the authors found that ultrasound-indicated cervical cerclage in twin pregnancies can decrease the risk of preterm birth and subsequent neonatal morbidity [4], drawing the similar conclusion in singleton pregnancies [5]. We congratulated the success of publication that enriched our knowledge of cervical cerclage in twin pregnancies. However, some questions are raised and we hope to receive the authors' response.

First, the authors said that pregnant women were discharged on the next day if there were no signs of labor or infection, and the authors prescribed four kinds of tocolytic agents but no prophylactic antibiotics to their patients [4]. Did the authors use prophylactic antibiotics after cervical cerclage in routine? If the authors used prophylactic antibiotics, could the authors kindly provide the following information to use, including the kinds of antibiotics, the dosages and durations, and the route of their prescription? After all, McDonald cerclage is a transvaginal operation and requires antibiotics to prevent infection, which can clean the cervicovaginal environment and improve the pregnancy outcomes [5].

Second, preterm delivery in twin pregnancies is multifactorial. It is known to all that twin pregnancies are associated with increased risks of maternal morbidities, such as pregnancy induced hypertension, preeclampsia, chorioamnionitis, gestational diabetes mellitus, intrahepatic cholestasis of pregnancy, etc. All of these complications are the common etiologies of preterm delivery. However, the authors did not exclude these patients in their article [4]. Did the authors have the data of these complications in the two studied groups?

Third, the authors found that ultrasound-indicated cerclage decreased neonatal morbidities, including respiratory distress syndrome, sepsis and neonatal intensive care unit admission, but the born mortalities of twin A and twin B were 3 and 1 respectively in the cerclage group as shown in their article. It is not clear that cerclage was especially beneficial for twin A?

Finally, we noticed that 9 women in the cerclage group had vaginal delivery in their article [4]. What is the gestational age to remove the cervical cerclage in twin pregnancies? Is it same at 36–37 weeks of gestation as singleton pregnancies [5]?

Could the authors kindly respond to the above-mentioned questions?

Declaration of competing interest

None.

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