Author's reply

Sir,

Miscarriage is one of the most common clinical problems that gynaecologists encounter every day, worldwide. Despite multiple studies on first-trimester miscarriage, there has been no significant change in management, in terms of both medical and psychological treatment, in the past two decades. Besides, there is a lack of high-quality study on the effectiveness of psychological intervention for women suffering pregnancy loss. Therefore, we believed our study, a randomised controlled trial to assess the effectiveness of a supportive counselling programme compared with 'standard' care upon psychological wellbeing following miscarriage, can be applied to current practice.

Although our results do not justify the routine counselling of all women following miscarriage, a supportive counselling programme for selected women with high levels of psychological distress may be more promising. We do believe that these results can be generalised to women of different ethnicity, or merits further investigation.

Gestational age at the time of pregnancy loss could affect the psychological impact. Previous studies on this issue are heterogeneous on patient recruitment, including miscarriage, late-pregnancy loss or even perinatal deaths. Thus, the results from these studies are not suitable to be applied in the management of women with miscarriages, the majority of which occur in the first trimester. Our study specifically targeted women with first-trimester miscarriage, aiming to formulate better post-miscarriage psychological care of women. The stratification of gestational age in first-trimester miscarriage may further identify risk factors for psychological distress, and further research is required to identify the 'high risk' group of women who would benefit from supportive counselling, apart from those with high levels of psychological distress reported from questionnaires.

For the treatment modalities in first-trimester miscarriage, our previous study did not demonstrate substantial differences in the psychological impact, women's preference and satisfaction for different treatment modalities.[1] Thus, we believe that the treatment modalities will not significantly alter the risk of psychological distress after miscarriage.

Healthcare professionals should pay attention to psychological morbidity after miscarriage and offer adequate support to these women; however, it is difficult to recognise women whom are in psychological distress after miscarriage. We suggest the use of the 12–item General Health Questionnaire (GHQ–12)[2] and the 21–item Beck Depression Inventory (BDI)[3] psychological questionnaires to assess the level of psychological distress, and to provide supportive counselling to women who have high levels of psychological distress. ■

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Re: Management of women with low-grade cytology: how reassuring is a normal colposcopy examination?

Sir,

As recommended by European Guidelines,[1] the key for improving the standard of care for patients with cervical intraepithelial lesions is the skill of the colposcopist, who also has the responsibility of facilitating shared decision making through patient information before, during and after the examination. The debate over best management of low-grade smear results is still open. The Italian Society of Colposcopy and Cervico-Vaginal Pathology, in the Guidelines on the Management of Women with Abnormal Cervical Cytology stated that women with low-grade cytological abnormalities should be immediately referred for colposcopic examination in an outpatient clinic.[2] This option was criticised because it may lead to overtreatment, complications and later adverse effects in young women, without clear psychological benefit. The article by Cruickshank et al.,[3] showing that after low-grade cytology and negative colposcopy the 3-year risk of cervical intraepithelial neoplasia stage 3+ is <1%, gives back to the colposcopist his central role in the management of cytological abnormalities. The return of women with negative colposcopy to routine recall with cytology at 3-year interval is an advantage from both a psychological and economic point of view. The main point remains the training and accreditation of colposcopy, because these results can be generalisable only in settings with quality-assured colposcopic practice. But this paper[3] may contribute to sensitise National Health Services about the importance of investing resources on colposcopic training. One suggestion that we could make is to restrict the use of a see-and-treat approach since the two-step approach, requiring a colposcopically obtained direct biopsy, as recently recommended by the Society of

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Obstetricians and Gynecologists of Canada,[4] is, in our opinion, preferable and favours a better training for colposcopist. ■

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Authors' reply

Sir,

Thank you for your interest[1] in our recent paper published in *BJOG* on the reassurance given by a normal colposcopy examination.[2] We agree that this highlights the importance of colposcopy training and accreditation, which are essential to maintaining the performance of a quality-assured cervical screening programme. ■

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Re: A report from #BlueJC: Can chewing gum prevent postoperative ileus?[1]

Author's reply

Sir,

Nowadays, doctors face an overwhelming quantity of information, even in narrow areas of interest. Therefore, many literature reviews are undertaken with the goal of describing a relationship, such as whether some intervention is effective at bringing about some change or whether two variables are associated.[1] When a review is performed systematically, following certain criteria, and the results are pooled and analysed quantitatively, it is called a systematic review and meta-analysis. A timely and methodologically sound meta-analysis can provide valuable information for researchers, policymakers, and clinicians.

We agree that a systematic review of high quality is best prospectively registered: for example, in the well-known database Cochrane Database of Systematic Reviews (CDSR). The registration process for the CDSR is complicated, however, and it usually takes a long period of time for a protocol to be approved. Therefore, although the number of systematic reviews published in peer-review journals has increased rapidly, those with prospectively registered protocols are still limited. We are glad to be notified that PROSPERO, an international prospective register for systematic review protocols, has been developed. We believe that the database, in which it seems much easier to register, would be helpful to avoid unintended duplication.

Postoperative ileus (POI) is characterized by the transient cessation of bowel function, lack of bowel sounds, accumulation of gastrointestinal gas and fluid, pain and abdominal distention, nausea, vomiting, and the delayed passage of flatus and stool.[2] The traditional end point of POI is the passage of flatus or a bowel movement. We also agree that the diagnosis of POI was not clearly defined in the primary studies included in our meta-analysis. The outcomes studied in our meta-analysis are only proxy outcomes for POI, and therefore do not support a reduction in POI. We can only draw the conclusion that gum chewing was associated with the rapid resumption of bowel motility.[3] ■

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