Training for certainty in the practice of medicine is said to begin in medical school.¹ Never before has there been such immediate access to high-quality information to help us proceed with confidence. Yet despite the availability of professional guidelines, consensus opinions, and electronic searches, we often are faced with clinical situations for which little (if any) information is available to guide our decision-making. In the absence of evidence-based medicine to lead us, we tend to fall back on our experience-based practice.

In this issue of Obstetrics & Gynecology, a new feature is being introduced to confront these dilemmas, titled “Clinical Conundrums” (see page 47 for the first article in the series).² A “conundrum” is defined as an intricate and difficult problem. This new venue will focus on a specific clinical question that the obstetrician–gynecologist faces in day-to-day clinical practice for which evidence for diagnosis, management options, or prognosis are deficient. The intent of this feature is not to do an exhaustive review of a topic but to concentrate on that one query that has no straightforward answer (ie, a clinical conundrum) and to provide a reasonable course of action.

In the first Clinical Conundrums article, we examine the controversial and highly debated management of the discovery of a short cervical length in a multiple gestation.² Drs. Gandhi and Fox tackle the clinical circumstance of an incidental short cervical length (less than 20 mm) noted on routine second-trimester anatomical ultrasound examination in a twin gestation in an asymptomatic, primigravid woman.² Obstetricians recognize the increased risk of preterm delivery and subsequent fetal morbidity in this clinical scenario. More than half of women with a twin gestation and a second-trimester cervical length of 20 mm or less will deliver before 34 weeks of gestation.³ Various interventions, such as reduced activity, progesterone supplementation (both intramuscular and vaginal application), cervical pessary, and cervical cerclage, have shown either no benefit or mixed results. A meta-analysis of the current evidence in twin gestations of the effectiveness of these methods (progesterone, pessary, or cerclage) in preventing preterm birth in the subgroup of women with a cervical length of less than 25 mm demonstrates no significant differences in preterm delivery at less than 34 or less than 37 weeks of gestation.⁴ The post-hoc data analyses were pooled data for a subgroup analysis. This subgroup was not the selection criteria used in the original study population, nor how those patients were originally randomized. When the patient is asking what may be done, it is arguable that clinicians will be hesitant to do nothing in a situation where the risk of early preterm birth is high.

So what is one to do when faced with this clinical quandary? In obstetrics and gynecology (as other specialties of medicine), examples exist where interventions have been advocated (often by consensus) as
being the most effective, but when evaluated in an objective fashion have shown no evidence of efficacy. The authors of the current report stress caution when the clinical evidence is not clear and what benefits may result at the expense of patient harm. Drs. Gandhi and Fox just as importantly point out therapies that have been of no benefit, but when the clinical information is conflicting, one should counsel the patient of interventions (such as vaginal progesterone or cervical pessary) that have shown limited treatment effectiveness in some clinical situations but not in others. Finally, the authors stress that we should encourage these women to participate in a formal clinical trial, if available, to help determine a definitive future answer, as has been advocated for some of the interventions discussed.

How then do we not retreat into our experience-based practice styles (and biases)? As American author F.L. Allen wrote, everything is more complicated than it looks to most people. Welcome to “Clinical Conundrums.”

REFERENCES