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 The authors report no conflict of interest.

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REPLY



Thank you so much for your keen interest in our article and your letter to the editor. I must commend you for your excellent work, your observation, and the outcome of your study. Vaginal progesterone appears to work only for women with a short and stable cervix, because the shorter the cervical length (CL), the higher the risk of spontaneous preterm birth.¹ However, in women with a short dynamic cervix and progressively shortening CL, especially <10 mm, vaginal progesterone alone was less effective compared with combined vaginal progesterone and cerclage as shown in our study.

Extremely short CL increases the risk of cervical dilation, which exposes the fetal membranes to pathogenic vaginal microbiomes. There is also the potential risk of stripping of the fetal membranes from the decidua attachment in the lower uterine segment. These 2 events increase the risk of intra-amniotic infection/inflammation that causes the release of cytokines and prostaglandin that invariably result in uterine contraction and spontaneous preterm birth.² There is currently

no recommendation on the optimal surveillance of cervical length once short cervix is diagnosed, but individual institutions should adopt a protocol based on their patients population and available resources. Our institutional policy includes serial CL measurement every 2 weeks for CL 20–25 mm and weekly for CL <20 mm up to 24 weeks when cerclage is placed if CL is <10 mm. After 24 weeks gestation, women with CL <20 mm may be monitored every 2 weeks up to 28 weeks gestation to enable early detection of patients with extreme short cervix who may benefit from betamethasone for fetal lung maturity. Serial CL measurements may require frequent visits by the patient, an increase in the healthcare staff work load, and economy cost; however, the benefits of additional intervention to reduce extreme prematurity quite outweigh the overall burden of CL surveillance. Finally, spontaneous preterm birth is as a result of interaction of multiple pathologic process such as cervical insufficiency, uterine irritability/contraction, and activation of fetal membranes—decidua interface.³ Therefore, interventions to reduce preterm birth will require a multimodal approach such as a combination of cervical cerclage and vaginal progesterone for those women who are at extreme risk of preterm birth. ■

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Re: Maternal age and risk for adverse outcomes



TO THE EDITORS: We believe that the study design of the paper “Maternal age and risk for adverse outcomes”¹ was mischaracterized as a retrospective cohort. As we have noted

previously,^{2,3} in a cohort study, participants are identified as exposed or unexposed to the factor of interest, regardless of outcome, and are then followed over time to determine who