Books

Endoscopic Management of Gynecologic Disease

Edited by David Adamson and Daniel C. Martin. Pp. 458. Illustrated. US$183. New York: Lippincott-Raven. 1995. ISBN 0-7817-0281-X.

This is a clear, concise book, providing an authoritative and detailed overview of gynaecological endoscopy and endoscopic surgery. Several world authorities on gynaecological endoscopy contributed and it deals with all important aspects of this new direction in gynaecological surgery. It is well illustrated with clear and tasteful photographs, which contributes to its value as a reference guide.

This book deals not only with endoscopic surgery, but also with diagnostic laparoscopy and hysteroscopy. An important feature is that of endoscopic energy, which is covered in two chapters, and one does not get the idea that any of the different modes of endoscopic energy are promoted at the cost of the others. Laser and electrosurgery enjoy equal emphasis, which in my opinion is of utmost importance as both have a definite role to play.

From the chapter of laparoscopic hysterectomy, it is clear that the authors portray the American viewpoint as far as this subject is concerned. Unfortunately, there is no chapter on laparoscopically assisted vaginal hysterectomy, although it is mentioned in the chapter dealing with indications for laparoscopic surgery.

The chapter by D. Alan Johns on 'Cost effectiveness of laparoscopic surgery' is very interesting and important for every endoscopic surgeon, because this is the aspect most talked about among medical aid schemes, doctors and patients.

In conclusion, this book is up-to-date and very readable. It is good value for money and is highly recommended for gynaecologists practising endoscopy and endoscopic surgery.

Paul Wessels

Briewe

Letters to the Editor

Is shoe size a reliable obstetric predictor of cephalopelvic disproportion?

To the Editor: We recently embarked on a project to investigate the relationships between maternal total body height (stature), weight, pelvic dimensions commonly used by obstetricians and shapes of pelvic cavities, and shoe size as a measure of foot size (i.e. foot length and foot breadth). Thereafter we attempted to establish whether maternal shoe size can be used as a reliable predictor of cephalopelvic disproportion.

It is generally accepted that larger women give birth to larger babies. Maternal stature and weight may therefore be used clinically in the prediction of whether or not a woman may require an elective caesarean section.[1] Long bones have been used extensively as a means of predicting total body height, both in anthropometry and in the analysis of archaeological specimens with their usually well-preserved long bones. Equations are readily available for the prediction of stature using foot length[2] and foot breadth,[3] calculations which are frequently done in forensic investigations. It is well known that the capacity of a woman's pelvis is related to her total body height.[4] Taller women have a lower incidence of contracted pelvises than their shorter counterparts.[5] In addition, taller women usually have a gynaecoid or anthropoid pelvis.[6] The deduction is that body height can be used as a predictor of pelvic proportions and therefore cephalopelvic disproportion.

This study was carried out in Cape Town between June and August, 1995. Permission was granted by the Medical Superintendent, Groote Schuur Hospital, to use some of the data on patients at Mowbray Maternity Hospital, as well as to obtain their telephone numbers. All women were from the so-called Cape Coloured community, in an attempt by us to try to rule out considerable genetic variations. The experimental group (63 women) comprised women who had an elective or emergency caesarean section for cephalopelvic disproportion or failure to progress. The control group comprised 70 women who had normal vaginal deliveries.

Data extracted from hospital records were maternal height and weight and infant birth weight and head circumference (in order to eliminate largeness of the fetus as a reason for dystocia, for example women who gave birth to a baby weighing more than 4 000 g were excluded from the study). Information obtained telephonically was maternal shoe size (a combination of foot length and foot breadth). All data were analysed using standard statistical packages.

The distribution of body heights for the two groups are as follows:

	Experimental group		*Control group*	
Height intervals (mm)	*No.*	*%*	*No.*	*%*
≤ 1 440	4	6.35	1	1.43
1 450 - 1 490	7	11.11	3	4.29
1 500 - 1 540	18	28.57	13	18.59
1 550 - 1 590	19	30.16	23	32.86
1 600 - 1 640	12	19.65	16	22.86
1 650 - 1 690	2	3.17	11	15.71
≥ 1 700	1	1.59	3	4.29
Total	63	100.00	70	100.00

Maternal height (mean ± SD) in those subjects who had vaginal deliveries (1 591 ± 64 mm) was significantly greater than in those requiring a caesarean section for cephalopelvic disproportion (1 550 ± 62 mm) ($t = 37.2$; $P < 0.005$).

There was considerable variation in the maternal weights recorded, and many of the women were heavy for their heights. Maternal weight in those delivering vaginally (65.7 ± 14.3 kg) was not significantly greater than in those delivering by caesarean section (64.2 ± 13.2 kg) ($t = 0.223$).

The distribution of shoe sizes for the two groups are as follows:

Shoe size intervals (British sizes)	*Experimental group*		*Control group*	
	No.	*%*	*No.*	*%*
≤ 3 1/2	9	14.29	6	8.57
4 - 4 1/2	19	30.16	18	25.71
5 - 5 1/2	22	34.92	21	30.00
6 - 6 1/2	11	17.46	20	28.57
≥ 7	2	3.17	5	7.14
Total	63	100.00	70	100.00

Maternal shoe size for the control group (5.2 ± 1.1) was not significantly different from that for the experimental group (4.7 ± 1.1) ($t = 2.178$).

Our conclusions are that, from the literature, there is a relationship between body height and adequate pelvic capacity; and, from the literature, that there is a relationship between shoe size and body height; from this study, we conclude that there is a relationship between shoe size and adequate pelvic capacity. Shoe size may be used as a predictor of cephalopelvic disproportion, but total body height is a far more reliable predictor.

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1. De Groot H. 4th-year obstetrics course lecture notes, Department of Obstetrics and Gynaecology, University of Cape Town, 1995.
2. Giles E, Vallandigham JD. Height estimation from foot and shoeprint length. *J Forensic Sci* 1991; **36:** 1134-1151.
3. Robbins LM. Estimating height and weight from size of footprints. *J Forensic Sci* 1986; **31:** 143-152.
4. Mahmood TA. Maternal height, birthweight, obstetric conjugate and their influence on the management of parturients with a previous caesarian scar. *Acta Obstet Gynecol Scand* 1989; **68:** 595-598.
5. Krassvec K, Anderson MA. Maternal anthropometry for prediction of pregnancy outcomes. *WHO Bull OMS* 1991; **69:** 532.
6. McCall Sellars P. *Midwifery: A Textbook and Reference Book for Midwives in South Africa*. Cape Town: Juta, 1993.