The objective of our systematic review was to determine the accuracy with which various types of tests for bacterial vaginosis predict spontaneous preterm birth in pregnant women, and we subdivided our analysis for asymptomatic and symptomatic women with threatened spontaneous preterm labour at presentation. The former explored the issue of testing accuracy for screening in early pregnancy, the topic of interest to Lamont et al., but we never intended to write a treatise to expound the greater understanding of pregnancy, the topic of interest to Lamont et al., but we never intended to write a treatise to expound the greater understanding of bacterial vaginosis and preterm birth. Lamont et al. claim that our review is not in line with current practice. However, as recently as 2002, primary research was evaluating this issue. Our review has now established scientifically that the diagnosis of bacterial vaginosis is clinically unhelpful in the prediction of preterm birth in women with threatened spontaneous preterm labour.

Lamont et al. suggest that the diagnosis of bacterial vaginosis in an attempt to prevent preterm birth should be limited to early pregnancy when antibiotic prophylaxis is most effective and tocolytics and steroids are not a consideration. It goes without saying that if early pregnancy antibiotic prophylaxis is shown to be efficacious, it could only be used effectively if an accurate test exists so that the antibiotic can be targeted appropriately. We would like to point out that testing for bacterial vaginosis had variable accuracy among asymptomatic women. For testing to be effective in combination with antibiotic prophylaxis in early pregnancy, it must achieve considerably better accuracy than that observed in the currently available literature. The comment concerning steroids and tocolysis is only pertinent for symptomatic women with viable pregnancy in whom bacterial vaginosis testing was not found to be accurate in our review.

We disagree that the inclusion of the gas–liquid chromatography was irrelevant. We intended to examine a complete list of tests for preterm birth and included gas–liquid chromatography for completeness. We did not find it to be accurate. If we had, no doubt, demand would have driven commercial manufacturers to produce faster devices.

Lamont and Taylor-Robinson’s comment about ‘historical evolution’ is odd considering that the very document (http://www.fda.gov/cder/present/anti-infective798/bacterial_vaginosis/index.htm) they quoted advises the use of Amsel criteria, which they themselves described as being ‘subjective, clumsy, unpleasant and irreproducible’. Our systematic review was neither a historical perspective nor an opinion. It was a protocol-driven scientific project. Learning from research evaluations of the past can help us to avoid pitfalls in future research and in bacterial vaginosis research should prevent us from ‘re-inventing the wheel’.

The suggestion that bacterial vaginosis testing should be conducted at a specific gestational time point requires careful analysis, and could be addressed in primary research or in reviews. We had planned to assess this issue, but due to the paucity of relevant data, it was not possible to do so in a statistically sound way. We look forward to the information the correspondents refer to in their letter finding its way through the peer-review process.

Lamont et al. are concerned that we did not include relevant references concerning effectiveness of antibiotic prophylaxis. To reiterate, our aim was to determine the accuracy with which various tests for bacterial vaginosis predict spontaneous preterm birth in pregnant women. Assessing effectiveness is already done by Cochrane reviewers. We alluded to research on effectiveness of antibiotic therapeutic effectiveness in our discussion to aid in interpretation of our findings. Of the three references we are alleged to have missed, one is an opinion and is neither a test accuracy nor a therapeutic effectiveness study. Its consideration in our review was not appropriate. The others were published after our review was submitted and are therapeutic effectiveness studies, which were ineligible for inclusion anyway.

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H. Honest, L.M. Bachmann, E.M. Knox, J.K. Gupta, J. Kleijnen & K.S. Khan
*Birmingham Women’s Hospital, Edgbaston, UK*

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