Letter to the Editor

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Habek's modification of Stark's techniques of cesarean section

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To the Editor,

After almost a century of using the Dörfler technique, Stark revolutionized the transperitoneal cesarean section (CS) technique with his own modification, which has become a proven and globally established method through numerous clinical studies. Recently, in his work, he has evolved his technique with a detailed description of the technique, commentary, and comparison of modifications and the outcomes of his and other techniques included istmocoelas and vaginal birth after caesarean (VBAC) [1].

In Croatia, the method has been established since 2002, and today it is either the method or the Habek technique. So, I personally published my own modification with my group in 2005, which I evaluated in further studies, which include: a preoperative catheterization of the urinary bladder, no ecarter insertion, supraplical incision without bladder dissection, suturing the hysterotomy with a single-layer non-locking suture, and no suturing of the subcutaneous tissue with an intracutaneous resorbable skin suture. The aforementioned modifications (>1,000 CS) have proven a better recovery of the mother with a lower percentage of isthmoceles, a higher percentage of VBAC, a significant reduction in prepartum and intrapartum uterine ruptures, as well as a reduction in placenta accreta spectrum disorders, especially with perkretism in the bladder due to the absence of vesicouterine peritoneoplication [2].

Recently, due to the global increase in the incidence of CS, the number of isthmoceles (niches) is also increasing, in addition to the stationary number of uterine ruptures, which can be connected to surgical techniques. Namely, some works indicated that single-layer non-locking sutures and non-peritonization are associated with a significantly lower rate of scar insufficiency because there is no strong inflammatory reaction, premeditated damage to the scar microcirculation by a tightly tightened locking suture, and the possibility of creating ischemic microsacculations, which results in poor scar quality [2–4].

In the current preliminary observational clinical study, we demonstrate a significantly higher frequency ($p<0.001$) of postoperative isthmoceles, silent and manifest prepartum uterine ruptures, with a reduced possibility of VBAC in hysterorrhaphy in cases with locking uterine suture, which increases the total number of repeated CS and uterine reconstruction procedures.

Respecting the immeasurable contribution of Stark's surgical-obstetric revolution in the new millennium, we conclude that our own long-term clinical experience and a preliminary observational study support that bladder dissection and omission, and locking hysterotomy suture are risk factors for the formation of istmocoele and potential uterine rupture, and we recommend the absence of bladder dissection with a non-locking single layer hysterotomy sutures. Our own published research supports the above, and current research suggests that they should be implemented into professional preferences for the purpose of good clinical practice in improving overall women's health.

Research ethics: The study was conducted in accordance with the Declaration of Helsinki (as revised in 2013).
Informed consent: Not applicable.
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