sleeve gastrectomy also found an increase in SGA in women who had a body mass index of <30 kg/m^2 before pregnancy compared with women who had a body mass index of >30 kg/m^2 before pregnancy (22% vs 4%; P=.05), despite both groups undergoing the procedure.[4]

Regarding the timing of the pregnancy after the procedure, most studies did not include this kind of information; thus, this is a limitation of our study. The evidence, however, that pregnancy outcomes are affected by close timing of pregnancy after surgery is still controversial, and findings have been mixed, with a number of studies finding no difference in outcomes despite differences in timing of pregnancy.[5,6] It is possible that continuation of weight loss during pregnancy vs weight stability is a more important determinant of pregnancy outcome than a fixed time of pregnancy after surgery.[7] ■

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Apparently conflicting meta-analyses on prophylactic negative pressure wound therapy after cesarean delivery

Check for updates

TO THE EDITORS: We read with interest 2 apparently discordant meta-analyses on the prophylactic negative-pressure wound therapy after cesarean delivery recently published in the American Journal of Obstetrics and Gynecology (AJOG)[1] and in Obstetrics and Gynecology.[2] According to the latter, "currently available evidence does not support negative-pressure wound therapy use among obese women for cesarean wound complication prevention" and the former considered the results suggestive of "a reduction in surgical site infection and overall wound complications."

Several sources of discordance between systematic reviews/meta-analyses have been described, including differences in objectives and methods or errors in implementation.[3] Regarding these 2 articles, their objectives were essentially the same, but there were differences in the search strategies, in study designs, and in outcomes selected for analysis. In the AJOG, both randomized controlled trials (RCTs) and cohort studies were used to compute pooled relative risk (RR) estimates with 95% confidence intervals (95% CI), whereas in Obstetrics and Gynecology only data from RCTs were analyzed. In the AJOG, the conclusions were driven by results regarding surgical site infection (RCTs: RR, 0.55; 95% CI, 0.35−0.87; cohort: RR, 0.32; 95% CI, 0.18−0.57; all studies: RR, 0.45; 95% CI, 0.31−0.66), despite data regarding other outcomes were also presented, including composite wound complications (RCTs: RR, 0.82; 95% CI, 0.57−1.18; cohort: RR, 0.45; 95% CI, 0.26−0.78; all studies: RR, 0.68; 95% CI, 0.49−0.94); in Obstetrics and Gynecology, the authors focused mostly on the composite outcome of wound complications (RCTs: RR, 0.97; 95% CI, 0.63−1.49). A composite outcome of wound infections was analyzed as well (RCTs: RR, 0.79; 95% CI, 0.44−1.41).

Despite the fact that the search strategies were comprehensive and covered analogous periods in both reviews, there was no complete overlap between them. There was 1 additional RCT in the AJOG article;[4] had it been included in the Obstetrics and Gynecology meta-analysis, the conclusions would be essentially the same for composite wound complications (RR, 0.82; 95% CI, 0.57−1.18), and a negative significant association would have been obtained for surgical site infection. Also, 2 additional cohort studies were identified in the Obstetrics and Gynecology report but were not eligible for this meta-analysis.

Summing up, weaker associations were obtained from RCTs and for the composite outcome of wound complications; the differences in the conclusions of these reviews were determined mostly by the choice of distinct primary outcomes by their

authors. This is an example of how the conclusions of transparent systematic reviews/meta-analyses may be subjective and influenced by methodologic options made by the authors. ■

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Magnetic resonance imaging for diagnosis of placenta accreta spectrum disorders: still useful for real-world practice

Check for updates

TO THE EDITORS: Einerson et al,[1] the leaders of placenta accreta spectrum (PAS) disorders (creta, increta, percreta), showed that magnetic resonance imaging (MRI) after ultrasound frequently leads to an incorrect diagnosis of PAS. MRI revealed clinically meaningful changes in only 19% of cases. They concluded that "MRI should not be used routinely as an adjunct to ultrasound in the diagnosis of PAS … until evidence is clearly demonstrated by more definitive prospective studies."

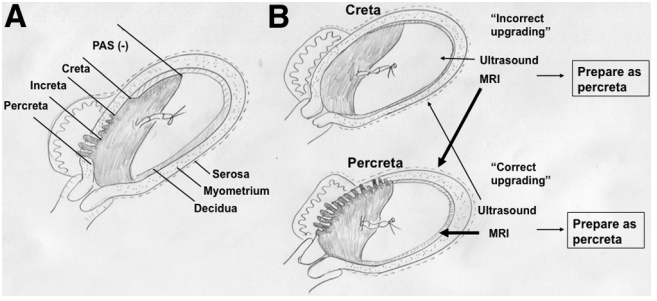
We want to interpret their data differently.

Of 78 patients, MRI altered the ultrasound diagnosis correctly/incorrectly in 15 (19%) and 13 (17%), respectively, being approximately equal. Thus, Einerson et al[1] rejected the adjunctive usefulness of MRI. However, we would like to note that in 7 patients (9%), the diagnosis was correctly upgraded to percreta. MRI, but not ultrasound, identified bladder invasion in 1 patient, for whom cystotomy was performed.

For presurgically diagnosed placenta percreta, we perform cesarean hysterectomy under aortic balloon occlusion and ureteral stent use, whereas for less-degree PAS, we perform it without these presurgery procedures in a case-by-case manner. If bladder invasion is severe, we perform intentional cystotomy using an automatic cutting and stapling device.[2,3] If the bladder invasion is too severe, we use placenta left in situ instead of hysterectomy to avoid life-threatening bleeding. Thus, the preoperative diagnosis of percreta markedly changes the strategy/preparation.

The data of Einerson et al should be interpreted that "as many as 9%" of patients were "correctly upgraded to percreta," greatly benefitting from MRI. Furthermore, because experienced obstetricians can usually discern percreta

FIGURE
Schema of PAS disorders and proposed diagnostic procedures



A, In creta, villous tissues attach to the myometrium without interposing decidua (adhesion abnormality), whereas in increta/percreta, villous tissues invade into/beyond the myometrium (invasion abnormality), respectively. **B**, Upper panel indicates creta and lower panel indicates percreta, with both diagnosed histologically. This figure shows an extreme example of upgrading by MRI scenario. In both creta (upper) and percreta (lower), ultrasound indicates creta, whereas MRI indicates percreta. Eventually ultrasound (upper) and MRI (lower), respectively, correctly diagnose the situation, which becomes evident in retrospect. When planning the surgery, adopt severe diagnosis (*bold line*) and disregard the less severe diagnosis (*fine line*) for safety. The final treatment strategy should be decided during surgery (see text).

MRI, magnetic resonance imaging *PAS*, placenta accreta spectrum.

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