Correspondence

Response to “The first-line approach for cesarean scar pregnancy: The most adopted being not the best”

Dear Editor,

I thank you and Dr Yang for your encouraging interest in my manuscript which is entitled “Systematic review: What is the best first-line approach for cesarean section ectopic pregnancy?” [1] As Dr Yang has most kindly specified, our manuscript brings forward interventional methods such as hysteroscopic and laparoscopic hysterotomy rather than medical methods for the treatment of cesarean scar pregnancy (CSP). Dr Yang has objected to a result of our manuscript which argues that uterine artery embolization (UAE) has a low success rate and a high complication rate as a first-line approach for CSP. Dr Yang has also hypothesized that several factors may be responsible for this argument about UAE.

The first factor is not applying strict criteria for screening the CSP cases that have been delineated in literature. It is true that a number of case reports have been included in our systematic review but it should be understood that CSP is a relatively new medical term and these case reports are valuable as the first scientific descriptions for the diagnosis and treatment of CSP. As cesarean deliveries have gradually increased in number, CSP has become more frequent and cases of CSP have accumulated to reach a number which is required to publish a case series or clinical study. These publications have usually focused on the success of a certain treatment method which has been adopted by a certain study center. We have presumed that specifically indicating the success of a certain treatment method by describing a series of cases and maybe not mentioning the failure of individual cases would also cause a selection bias.

For this reason individual case reports have been considered as independent trials for the diagnosis and treatment of CSP prior to the establishment of management methods for this clinical entity.

Moreover, Dr Yang has contravened our methodology whereby the efficiency of a therapeutic option is assessed by whether this option leads to a high complication rate and whether the patients treated with this option need a secondary treatment. It has been argued that the failure rate of a treatment method may be high but the hysterectomy rate may be low because treatment methods may be combined. However, this manuscript seeks the best first-line approach for the treatment of CSP instead of looking for the best combined treatment. In other words, the aim of our research has been to define the treatment method which would achieve the highest success rate with the lowest complication rate at the first step. The absence of any requirement for any complementary treatment and the lack of any need for urgent treatment would surely provide a superior therapeutic option.

In literature, most patients treated with UAE are cases where the first-line approach of dilation and curettage has been later complicated by excessive uterine bleeding. This has been addressed as the major reason for the discrepancy between our manuscript and that of Birch-Petersen et al [2]. Such an occasion has been considered as a therapeutic failure rather than a successful combined treatment because of the sudden occurrence of life-threatening hemorrhage. We think every clinician would regard the value of treating a CSP without being exposed to the risk of managing an excessive uterine bleeding.

In addition, there are a number of CSP cases which have also been complicated by excessive hemorrhage after being primarily treated with UAE. This failure of UAE may be attributed to the incompetency in the interventional skills and techniques. Therefore, I agree with Dr Yang’s comment that the success of a treatment method (especially an interventional one) depends on the familiarity of the clinician with this method. It would be prudent to suggest that UAE might be the most efficient first-line treatment in adequately skilled and experienced hands. At the beginning of our manuscript, we have chosen the most frequently adopted therapeutic regimens for CSP because the utilization of recently defined techniques such as transvaginal hysterotomy has not been widespread and standardized enough to draw a definite conclusion about its efficiency.

In conclusion, we believe that the efficiency of a therapeutic option is based on its association with serious complications (i.e., heavy bleeding) and the requirement for urgent complementary treatment. Any method developed for the treatment of CSP is expected to annihilate this type of ectopic pregnancy as quickly and smoothly as possible. Thus, the failure of a treatment method can be accepted if this method has been unable to dissolve CSP and also has increased the risk of exposure to heavy hemorrhage and urgent hysterectomy.

In our research, hysteroscopic resection of CSP and laparoscopic hysterotomy have emerged as efficient, safe, feasible, and attainable alternatives for the treatment of CSP.

Conflicts of interest

The author has no conflicts of interest relevant to this article.

References


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