



Intrauterine sutures in cesarean section for placenta previa: some concerns

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Dear Editors,

Ryu et al. [1] devised a new hemostatic suture for cesarean section for placenta previa, “continuous suturing in the inner surface of a lower segment”. Patients with this suture (Group A: $n = 104$) bled significantly less than those without it (control, Group B: $n = 173$). We have some concerns.

First, the study target was unclear. They enrolled 277 women with placenta previa delivered by cesarean section. We wonder whether the study included: (a) all consecutive patients with previa irrespective of the occurrence of massive bleeding, or (b) patients with bleeding requiring some additional hemostatic procedures. In scenario (a), their procedure was prophylactic, whereas in (b) it was therapeutic. A recent report [2] suggested that prophylactic Bakri balloon placement for previa reduced bleeding, which we also sometimes employ, especially when massive hemorrhage is anticipated [3]. We believe that suturing the inner surface may be somewhat invasive, and, thus, if scenario (a) was the case, we wish to know the rationale for prophylactic suturing. If (b) was the case, we wish to know its indication.

Second, the control was unclear. The employment of various intrauterine sutures for previa has already been reported [4, 5]: intrauterine suture per se is not new. Therefore, Ryu et al.’s point was the superiority of this specific suture over other intrauterine sutures. Thus, a comparison should have been made regarding the hemostatic effect between this new suture and the conventional figure-of-eight suture, which, however, was not the case. Groups A (new suture) and B (control) were compared, with the latter consisting of patients “receiving ‘other’ bleeding control methods, including figure-of-eight sutures”; “other” methods were used in

the control. It is unclear in the control group: (a) whether all 173 patients underwent figure-of-eight suture and, if so, (b) whether procedures other than intrauterine sutures were also used. Most of their discussion consisted of description of the superiorities of intrauterine suture over uterine compression suture. This is not so; however, the superiority of this new suture over orthodox intrauterine suture should have been discussed.

Third, procedures should have been described in a more detailed manner. How should a needle be placed in a deep area adjacent to the internal ostium in the presence of massive hemorrhage? Some clinicians have used uterine artery clamping to obtain a dry field to place adequate intrauterine sutures [4]. Next, the anterior lower segment is difficult to directly observe and thus to access from the hysterotomy window. Was this area everted? If so, could all these parts be everted from a narrow hysterotomy window? Last, a problem may occur in patients with a cesarean history. The lower segment frequently becomes very thin and tightly adheres to the bladder. Intrauterine sutures may destroy this weak tissue and the needle may easily pick-up the bladder, causing bladder injury.

We commend Ryu et al. for their novel hemostatic procedure for previa surgery. However, we feel that the study design and procedure should be described in a more reproducible manner, which may aid obstetricians struggling to manage placenta previa.

Author contributions SM: identification of the significance and manuscript writing. ST: manuscript co-writing and manuscript editing. HT: manuscript co-writing and manuscript editing.

Compliance with ethical standards

Conflict of interest The authors report no conflict of interest.

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