Medical evacuation of the uterus and subsequent preterm labor

TO THE EDITORS: Several systematic reviews draw attention to a relationship between medical or surgical evacuation of the uterus and subsequent preterm labor though do not suggest potential mechanisms. Saccone et al 1 conclude that “Prior surgical uterine evacuation for either induced termination of pregnancy or spontaneous abortion is an independent risk factor for preterm birth. These data warrant caution in the use of surgical uterine evacuation and should encourage safer surgical techniques as well as medical methods.”

With the restrictive family planning policies in China in recent years, many women have had recurrent or “late” (>12 weeks), surgical or medical evacuations of the uterus. Both may result in injuries to the uterosacral ligaments and the uterovaginal nerves that run through the center of these ligaments. Excessive traction to the cervix during surgical evacuation may cause asymmetric injuries to these ligaments (Figure, A) whereas excessive uterine activity associated with medical evacuation (10-15% of women in some series) may result in symmetric attenuation or complete absence of the uterosacral ligaments (Figure, B). Concomitant injuries to vasomotor nerves result in narrowing of arterioles throughout the lower genital tract that is associated with many of the “great” obstetric syndromes including mid-trimester loss, preterm labor, and preterm premature rupture of membranes.2 Medical evacuation complicated by excessive uterine activity may increase the risk of preterm labor compared to surgical evacuation (<12 weeks) in some groups of women. Many Chinese women experience high rates of subfertility, ectopic pregnancy, and pregnancy complications including preterm labor. We believe that denervation of the lower genital tract may create the conditions for “opportunist” infection and some forms of preterm labor.3 Other surgical interventions such as conization of the cervix may contribute to increasing rates of preterm labor through similar mechanisms.4 Both may be largely preventable.

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The authors report no conflict of interest.

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REPLY

We thank Dr Quinn et al for their interest in our study.1 Their analysis of data available with the Physician Payments Sunshine Act is revealing when they highlight that 765 gyneco-oncologists accepted research-unrelated payments totaling $1,957,004 in 2014 (mean value $2500 each), 48 receiving >$10,000.1 This way of portraying the evidence to the contrary.2 In addition, mere disclosure of conflicts of interests does not make them disappear. We should avoid euphemisms such as “social events and industry symposia” when they are actually “sham events to increase prescribing.”3

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The Physician Payments Sunshine Act: a smokescreen if no action!

TO THE EDITORS: The call of Shalowitz et al1 for action regarding interactions with industry is a commendable beacon. We applaud the clarity: Interactions are “strongly discouraged” (see Table1) because, of course, industry’s aim is “to influence (prescribers) behavior” and “transparency by itself is not a sufficient solution.” However, industry continues to argue that it “plays a valid and important role in the provision of medical education …” and that “medical representatives can be a useful resource for healthcare professionals …” despite evidence to the contrary.2 In addition, mere disclosure of conflicts of interests does not make them disappear. We should avoid euphemisms such as “social events and industry symposia” when they are actually “sham events to increase prescribing.”3

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