introduced aspirin and its postulated mechanisms of action to prevent preeclampsia.

Firstly, they note that aspirin may be inhibiting thromboxane, platelet activity, leading to the inhibition of “acute atherosclerosis” (and this “maintains circulation in small diseased blood vessels”). We had already mentioned that aspirin “may decrease endothelial dysfunction (blood vessel) dysfunction,” but thank McMaster-Fay and Hyett1 for this further level of detail.

In relation to our comment that “aspirin may facilitate early placental embedding,” they present evidence2 they propose refutes the concept that aspirin might facilitate spiral arterial remodeling, or “physiological change.” Specifically, they refer to their own work3 and interpret their findings to mean aspirin did not change uteroplacental resistance (measured by Doppler ultrasound) by 24 weeks’ gestation. Given this, McMaster-Fay and Hyett1 propose the more likely mechanism of action by which aspirin prevents preeclampsia is platelet inhibition.

We respectfully disagree the work they cite4 represents particularly definitive evidence that aspirin has no effect on placental embedding. It is an unpublished conference abstract and the data are not derived from a clinical trial where women were randomized to receive aspirin or placebo. Instead, it is a retrospective study where they appeared to have compared a historic cohort (41 women screened as high risk of developing preeclampsia but were not given aspirin) vs a cohort identified in a later period (291 screened as high risk of developing preeclampsia and offered aspirin). Among those who were presumably advised to take aspirin, it is difficult to determine who actually took the drug, their compliance, and the gestation at which it was commenced. No statistical comparisons were presented, and no formal power calculation was performed.

However, we do agree with the overall sentiment that whether aspirin prevents preeclampsia by influencing placental embedding remains speculative and unproven, which is implied in our editorial.

REFERENCES

Pelvic floor trauma and maternal age

TO THE EDITORS: We read with interest the recent publication by Rahmanou et al5 that found risk of pelvic floor trauma increased with maternal age. We reviewed our database of >126,000 births in the years 2003 through 2015 and found that was not the case in our population. There were 25,942 primiparae with spontaneous or instrumental vaginal deliveries; among them, there were 262 cases of third- to fourth-degree tears (1.0%). We examined the rate of obstetric anal sphincter injuries in successive cohorts of maternal age at delivery from 16-45 years. The figure shows that the rate of third- to fourth-degree tears was fairly steady in all age cohorts, ranging from 0.2-2.3%, and was nil in some small cohorts.

We speculate that the age distribution of our large patient cohort as well as different delivery ward protocols may account for the difference between our results and those of Rahmanou and colleagues.1 Their results may not reflect the age distribution of obstetric anal sphincter injuries in other populations.

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We thank Drs Yagel et al for their comment and appreciate that they have not been able to confirm an association between maternal age and obstetric anal sphincter injuries in their own obstetric service. In fact, this association did not reach significance in our own study (P = .13). However, there is evidence in the literature that, at least in some populations, sphincter trauma may indeed be more prevalent in older women having their first child,1-3 and this also seems to be the case for levator trauma.4-6

Hence, we would like to reiterate the main conclusion of our article: advancing maternal age increases the risks of multiple negative birth outcomes, including pelvic floor trauma, and such increased risk should be disclosed antenatally. The risk profile of vaginal vs cesarean birth clearly varies from one individual to the next, and one of the main variables is maternal age. The older someone is at the time of her first birth, the greater the potential benefit of avoiding vaginal birth.

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REFERENCES