Society for Maternal-Fetal Medicine Consult Series
#51: thromboembolism prophylaxis for cesarean delivery

TO THE EDITORS: We appreciate the detailed, evidenced-based review of thromboprophylaxis for cesarean delivery in “The Society for Maternal Medicine Consult Series #51: thromboembolism prophylaxis for cesarean delivery.” In their recommendations, the authors state, “Compared with UFH [unfractionated heparin], enoxaparin has the advantage of better bioavailability, longer half-life, more predictable anticoagulation effect, less bleeding risks, and less risk of heparin-induced thrombocytopenia and osteopenia. We recommend the use of LMWH [low molecular weight heparin] as the preferred thromboprophylactic agent in pregnancy and the postpartum period. (GRADE 1C).”

We agree that low molecular weight heparin (LMWH) may be preferred in many clinical circumstances compared with unfractionated heparin (UFH) including for antenatal outpatient prophylaxis for at-risk women. However, we are unaware if there is evidence that LMWH, on balance, offers substantial advantages compared with UFH at low doses for short periods for women immediately after cesarean delivery while in the hospital. It seems that heparin-induced thrombocytopenia is rare among obstetrical patients, and the risk of osteoporosis is generally associated with long-term therapy. In the setting of short-term, low-dose administration, we are not aware of evidence of increased risk of bleeding risk or decreased efficacy in young, generally healthy patient populations such as reproductive-age women. Although dosing is less frequent with LMWH, a major advantage of UFH is that it may be initiated relatively early after cesarean delivery in relation to neuraxial procedures. For example, at our center, UFH is administered routinely after cesarean delivery upon postanesthesia care unit discharge. In comparison, there may be up to a 24-hour interval after neuraxial block depending on the dose of LMWH. Given that (1) there may be potential clinical and operational benefits to shorter interval dosing after cesarean delivery and (2) we are not aware of any increased risk or decreased efficacy with UFH, we ask the authors for further clarification as to the potential substantive drawbacks with UFH compared with LMWH other than more frequent dosing.

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REFERENCES
Evidence is lacking for routine prehysterectomy screening for bacterial vaginosis

TO THE EDITORS: The expert review on bacterial vaginosis (BV) and surgical site infections (SSIs) provides an important and comprehensive review of postoperative complications associated with BV. The review recommends preoperative screening of women for BV before hysterectomy, and women receiving positive test results, regardless of symptoms, should...