which avoids the limitations of SUCRA, they might get different but more reliable rankings.

In conclusion, when ranking the effectiveness and/or harm of treatments in an NMA, we suggest that the authors should not only rely on the SUCRA scores of treatments but also consider the certainty of evidence to avoid making misleading conclusions. ■

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Postsurgical antiadhesive barriers to reduce the risk of recurrence after hysteroscopic adhesiolysis: a reply

We would like to thank He et al[1] for their interest in our network meta-analysis evaluating the efficacy of postsurgical antiadhesive barriers to reduce the risk of recurrence after hysteroscopic adhesiolysis.[2]

The authors expressed their concern regarding the lack of the Grading of Recommendations Assessment, Development, and Evaluation (GRADE) criteria to assess the certainty of the evidence of the evaluated outcomes, especially for the primary outcome (intrauterine adhesions recurrence). He et al[1] concluded that the lack of the GRADE criteria could deliver misleading conclusions.

It is indeed true, and we agree with He et al[1] that the use of the GRADE criteria would have been an added value to validate the reported evidence.[1] However, it should be acknowledged that our approach for study selection adopted extremely strict criteria, which resulted in including only high-quality, with low risk of bias, articles in the quantitative synthesis and network meta-analysis. In addition, to confirm the considerability of the evaluated evidence for both direct and indirect comparisons, the Separating Indirect from Direct Evidence—splitting method was used. This approach enhances the possibility that the considerability of results is related to the effects of the interventions rather than randomness.[3] At the same time, there was no inconsistency reported for both direct and indirect comparisons among the study outcomes, which also increases the validity of the main findings.

Considering all the aforementioned elements, although agreeing with He et al[1] regarding the importance of implementing GRADE criteria, we believe that the conclusions of our network meta-analysis must be considered appropriate. As we stated in our article and its conclusions, because of the lack of a superior approach among the analyzed barrier strategies, it is necessary to carry out further research to validate and confirm these findings. We hope with our article to encourage the research community to perform the needed additional studies to provide clinicians with valuable information on this fascinating topic. ■

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Conservative management of placenta accreta spectrum: is it time?

TO THE EDITORS: We read with great anticipation the PACCRETA prospective study and applaud the authors for this important work.[1] With the increasing incidence of placenta accreta spectrum (PAS), we welcome trials investigating conservative management. The findings supported the recent International Federation of Gynecology and Obstetrics guidelines on conservative management of PAS and will likely result in wider adoption of this technique.[2] However, we have concerns regarding broad acceptance in the United States, outside of research protocols and centers with experience with conservative management. Here we highlighted, why we continue to support the American College of Obstetricians and Gynecologists and the Society for Maternal-Fetal Medicine consensus statement on PAS, recommending hysterectomy as the standard management.[3]

First, the results of this study were not generalizable to the United States, where multidisciplinary care is common and has led to reduced morbidity and mortality for PAS. In contrast, only 19.4% of patients in this study benefited from such care.[1] In addition, when performing immediate hysterectomy, we followed clinical guidelines recommending against placental removal to minimize blood loss at delivery; however, in PACCRETA, surgeons attempted placental removal in most hysterectomy cases. Finally, the primary outcome in the conservative management group was similar to that reported for immediate hysterectomy in high-volume PAS centers.[4]

Thus, we encourage providers to take these results in the context of local resources and outcomes. Given the geographic differences between France and the United States, and the 1 in 5 incidences of emergent delayed hysterectomy in the PACCRETA study, we fear that broad adoption of this strategy will have consequences not studied in the PACCRETA population. There likely is a role for conservative management in certain settings, but we in the United States seek continued prospective investigations rather than widespread adoption. ■

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