We thank you for your letter and the interest that you have shown in our case of uterine necrosis.1

We reexamined the case with the medical staff and the resuscitators; in fact, postpartum hemorrhage still remains the obsession for us obstetricians and resuscitators, and we do not yet have enough information about the exact origin of uterine necrosis, which is a rare and unpredictable complication.

When faced with severe postpartum hemorrhage with an unstable patient, many surgical techniques could be used, and hysterectomy remains the reference solution in this context.2 However, new conservative surgical techniques have emerged that are easier to run and less aggressive and are being used more often. Nonetheless, these techniques may lead to complications, which although rare, could be serious, such as necrosis uterine.3

Given what we are experiencing, 3 things must be avoided to minimize this complication that still remains poorly understood in terms of its physiopathology. They are as follows:

1. Hermetic ligation of vessels to allow basic vascularization via low flow toward the uterus; moreover, do not consider the anastomotic networks alone.

2. Avoid, as much as possible, the association with other vascular ligature (lumbar ovaries) and associated compressions such as the modified B Lynch, which has also been mentioned in the articles by Linfeng et al3 and Benkirane et al.4 Excessive folding of the uterine wall owing to suture compression may have unpredictable effects on the uterine myometrium and endometrial vessels.4 Considering these adverse gynecologic outcomes, uterine compression suturing should not be employed concomitantly with vascular ligation.3

3. Finally, avoid the chances of associated infections by systematic vaginal sampling in the third trimester, and promote good asepsis during surgery and antibiotic coverage in case of doubt about any undiagnosed prepartum infection, which may potentiate hypoxia and the risk of necrosis.

In conclusion, uterine necrosis may be secondary to all these intertwined factors and could be potentiated by an environment of hypoxia, hypoperfusion, hypovolemia secondary to hemorrhage, massive transfusions with disadvantages in a patient who is immunocompromised by pregnancy, and possibly, by other vitamin and iron deficiencies.

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