Angular pregnancy: a reply

Naftalin et al stated that “angular pregnancy” was an outdated term for a laterally positioned but correctly sited pregnancy that is not associated with adverse pregnancy outcomes. Based on it being a wanted, potentially viable pregnancy, they considered this case as an unnecessary termination and that hysteroscopy should have been avoided.

We agree that “angular pregnancy” refers to an eccentric intrauterine pregnancy that should always be distinguished from an interstitial pregnancy, and expectant management with close interval follow-up is encouraged. In this case, the patient was indeed initially managed in accordance with this principle after being diagnosed with an angular pregnancy. However, ultrasonography 1 week later showed a low myometrial thickness of 2.8 mm. After being informed of the risks, the patient requested to proceed with termination and signed informed consent. Thereafter, it was no longer a wanted pregnancy, so the comments based on “a wanted pregnancy” would not be applicable.

Given the limited literature on this rare condition, the diagnosis and management of angular pregnancy remains controversial. An earlier published review described 39 cases of angular pregnancy and reported a 38.5% rate of spontaneous or missed abortion in expectantly managed cases; it also reported that “a crude estimate of the chance of an angular pregnancy causing an otherwise normal uterus to rupture would be 13.6%.” More recently, Bollig and Schust reported a large cohort including 42 cases of angular pregnancy with expectant management, among which approximately 20% had missed abortion, 15% had preterm birth, and only 65% resulted in full-term birth. Beside, only 2 out of 42 cases had a myometrial thickness <3 mm (as was in our case), and 1 among them resulted in incomplete abortion. Regardless, some maternal factors might be involved, and angular pregnancy was associated with unfavorable outcomes such as spontaneous and missed abortion, incompetent abortion and bleeding, preterm birth, and uterine rupture in literature. The application of hysteroscopy can accurately locate the implanting site, distinguish angular pregnancy from interstitial pregnancy and avoid unnecessary laparoscopy, ensure a complete removal of the products of conception, and reduce intraoperative and postoperative complications.

Regarding the consensus (not evidence-based) made by The European Society of Human Reproduction and Embryology or ESHRE Working Group on Ectopic Pregnancy in 2020, the term “angular pregnancy” was proposed to be abandoned, and “eccentric pregnancy” was recommended by other colleagues. However, in the literature published after 2020, “angular pregnancy” is still the most commonly used and acceptable term for this condition.

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Tranexamic acid for cesarean delivery: induction of a regimen for postpartum hemorrhage?

TO THE EDITORS: We read with great interest the study by Seifert et al, who assessed the pharmacokinetics (PK) and pharmacodynamics (PD) of tranexamic acid (TXA) administered to women at risk for postpartum hemorrhage (PPH) undergoing cesarean delivery. A combined assessment of PK and PD is meaningful in elucidating a clinically effective level of TXA, as multiple modifiers of bleeding and fibrinolysis interact during PPH. The authors empirically selected a target TXA plasma concentration (>10 mg/L). All patients had a TXA level >10 mg/L at 1 hour, which was maintained in more than half of the patients at 3 hours. Although these data seem to suggest that the studied TXA dosing should cover a
Tranexamic acid for cesarean delivery: evidence of fibrinolysis?

We read the letter “Tranexamic acid for cesarean delivery: induction of a regimen for postpartum hemorrhage?” in response to our publication “Tranexamic acid administered during cesarean delivery in high-risk patients: maternal pharmacokinetics, pharmacodynamics, and coagulation status.” We agree that using systemic whole blood to detect postpartum hyperfibrinolysis with rotational thromboelastometry (ROTEM; Instrumentation Laboratory, Bedford, MA) may have limitations. We saw no evidence of hyperfibrinolysis in peripheral samples by comparing EXTEM (ROTEM without aprotinin) vs APTEM (ROTEM with aprotinin) clotting time and maximum clot firmness (MCF). Lack of peripheral hyperfibrinolysis may indicate an absence of hyperfibrinolysis or early localized hyperfibrinolysis sequestered within the uterus. Despite these limitations, ROTEM has previously identified profound hyperfibrinolysis and can demonstrate coagulopathy during severe postpartum hemorrhage (PPH).1

The authors inquire whether our FIBTEM (ROTEM for assessing fibrinogen levels and fibrin polymerization) testing indicated platelet-driven clot retraction and not actual clot lysis. Our EXTEM and FIBTEM results showed no evidence of this, as EXTEM maximum lysis was zero in 18 (90%) of our patients, and no lysis >15% was detected in any sample from 30 minutes to 5 hours. There was no control group, as our primary endpoint was to evaluate the central tendency with no control group. We agree that studies are warranted to identify which assays, such as D-dimer or plasmin-antiplasmin complexes, detect clinically significant hyperfibrinolysis.

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