



Correspondence

Sclerotherapy for placenta accreta: Some concerns



Dear Editor,

Malagón Reyes et al [1] proposed a novel procedure to reduce bleeding during cesarean hysterectomy for placenta accreta (accreta, increta, and percreta). Vessel-sclerosing polidocanol solution was injected through an umbilical vein cannula and the bilateral internal hypogastric arteries were ligated, followed by hysterectomy, leading to a relatively small amount of bleeding [average: 2.7 L (range: 2.5–3.0)]. We have some concerns.

First, to what extent maternal vessels were sclerosed is unclear: both too little and too much sclerosis may cause problems. They stated that “the umbilical vein is cannulated with a 6Fr neonatal feeding tube upon its reach the placental bed,” meaning that the tube was inserted via “fetal” vessels to its dead end. This does not guarantee tube placement in the maternal vessels. The tube may have been placed within “fetal” vessels in some cases, in which case, “fetal” and not “maternal” vessels were mainly sclerosed. Except for very rare occasions in which the placenta is amputated (amputation-first technique (Matsubara) [2]), bleeding occurs mainly from the maternal and not fetal vessels [3]: sclerosing fetal vessels may not reduce bleeding. On the contrary, sclerosant may progress beyond the uteroplacental circulation, which may cause various problems including tissue ischemia. In sclerotherapy for saphenous vein varicose, the saphena–femoral junction is usually tightly compressed, thereby preventing the propagation of sclerosant to the draining femoral vein. How much sclerosant enters the maternal vessels may depend on various factors, including the tube insertion strength/site, infusion pressure, and vessel volume/strength/morphology: these may differ in a patient-by-patient manner. The vessel-sclerosis extent may differ individually, which is problematic.

Second, infusing sclerosing solution through the umbilical vein may cause partial placental separation with resultant massive bleeding. Saline infusion through the umbilical vein was previously attempted, aiming to hasten placental separation [4]. In many cases of placenta accreta, some placental parts show accreta, whereas others do not. Partial placental separation sometimes occurs at the “without accreta” part [3]. On partial placental separation, some maternal vessels remain intact without having undergone sclerosis, opening to the placental separation surface, from which massive bleeding can occur.

Third, one maternal death occurred due to “coagulopathy.” A bleeding amount of 2.5–3.0 L may not have caused dilutional coagulopathy. Infusion of sclerosing solution may raise the retroplacental pressure, which may have been associated with the

coagulopathy, similar to the coagulopathy observed at placental abruption. We wish to know the specifics of the situation surrounding this maternal death.

Lastly, it is unclear which of the two procedures sclerotherapy and hypogastric artery ligation reduced bleeding. We believe that hypogastric artery ligation reduces bleeding during this surgery [3,5], which Malagón Reyes et al [1] also stated. Data with “only hypogastric artery ligation without sclerotherapy” are necessary in order to propose the bleeding-reducing effect of their sclerotherapy.

We applaud Malagón Reyes et al [1] for proposing a novel procedure for this life-threatening surgery. However, any novel procedure should be based on theoretically sound grounds and its safety should be confirmed. Until these three concerns have been clarified/resolved, less experienced obstetricians should not blindly adopt this procedure, especially considering that maternal death actually occurred.

Conflicts of interest

The authors have no conflicts of interest relevant to this article.

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