Reply to "Placenta Previa Accreta and Previous Cesarean Section: Some Clarifications"

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First, we want to thank the readers for their comments about our study design. Their opinions about the possible reasons why elective (labor −) cesarean section (CS) leads to higher risk of placenta previa accreta are really valuable and make good sense.

Second, we are quite impressed by their strategies to reduce the occurrence of accreta after elective CS. The first strategy is to delay the timing of CS or perform oxytocin administration to change labor (−) CS to labor (+) CS. This strategy is in consistent with lowering the incidence of nonmedically indicated CS. However, there are still many precautions in oxytocin administration before CS. Some patients may not respond well and still lack uterine contractions after oxytocin administration. On the other hand, induction of labor by oxytocin should be based on strict medical indications, not all patients are indicated to oxytocin, some patients are even contraindicated.[1,2] Moreover, oxytocin has been shown to have side effects on women such as tachycardia, chest pain, palpitations, dyspnea, and nausea.[3] Our current results are not sufficient to draw the conclusion that oxytocin is applicable to all patients before CS. However, this might provide valuable reference for clinicians. Moreover, as mentioned by the readers, the effect of uterine contractions on the lower uterine segment is not determined yet, and still need further investigation. In short, oxytocin administration before CS is still controversial but worth further investigation. The second strategy is to make more "caudal" lower incision in lower segment which might decrease the damage to uterus. To verify this conception, more clinical and ultrasonic data are required to prove that more "caudal" lower incision leads to thinner lower uterine segment afterwards.

In summary, we still need more exploration and further discussion for these two strategies.

References

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