Unexplained infertility remains one of the most frustrating infertility diagnoses, for both patients and physicians. Without the benefit of a specific diagnosis, patients are offered empiric treatments, which include controlled ovarian hyperstimulation (COH) to produce multiple follicles in an effort to increase monthly fecundity. Therein lies the risk of multiple pregnancy, 10- to 20-fold above the natural rate (7.5% to 29%).

The alternative to COH is IVF, the most successful fertility treatment. The risk of multiple pregnancy with IVF is 30.2%, with a high-order multiple birth rate of 1.1%, related in both cases to the number of embryos replaced. Only in Quebec, with the application of an elective single embryo transfer policy for a total of three IVF cycles, do we see the risk decreased to 5.2% with a concomitant acceptable pregnancy rate. For the vast majority of couples, IVF is not funded and may be financially out of reach. Moreover, IVF may not be acceptable to all patients because of the associated ethical, financial and emotional costs. Consequently, other avenues of treatment such as COH with clomiphene or gonadotropins are discussed. We agree that general public access to IVF treatments across Canada could be beneficial in the prevention of multiple births and their consequences.

This case led to a reconsideration of practice in our clinic. Patients are carefully counselled about options for treatment of unexplained infertility. While IVF is definitely the most successful treatment, the cost of treatment is considerable and often factors significantly in decision-making. While we, and our patient, are thankful for the ultimately very positive outcome, we recognize the burden of risk that resulted from the treatment provided. This has reinforced the importance of having up-front frank discussions with patients about risks of multiple pregnancy, and cycle cancellation in the event of a multifollicular response.

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REFERENCES

hysterectomy, if performed by experienced surgeons, may be less invasive than open surgery. Does this hold true also for postpartum hysterectomy? I recently described the hidden danger of “conserving” management of PPA in this Journal. In short, a “conserving” strategy frequently requires emergency peripartum hysterectomy, which is dangerous because a multi-disciplinary team is difficult to assemble at night. I believe that this also holds true for a delayed hysterectomy strategy and even more for laparoscopic hysterectomy. Arendas et al. concluded that “Key factors for success consist of (1) a multi-disciplinary approach, (2) the availability of skilled laparoscopic surgeons, (3) advanced endoscopic equipment, and (4) the availability of resources (including blood transfusion).” In many institutions, all four of these are quite difficult to obtain for emergency surgery at night.

Peripartum hysterectomy requires many measures different from routine hysterectomy. I myself devised various measures, some of which were briefly described in this Journal. We must also consider the rarity of Caesarean hysterectomy due to placenta accreta. In the Placenta Clinic at Mount Sinai Hospital in Toronto, with a catchment area of 80,000 deliveries per annum, 68 patients had placenta accreta to the extent that Caesarean hysterectomy might be required during a 10-year period, indicating that Caesarean hysterectomy for this condition may be performed in approximately 1/10,000 deliveries. Since peripartum hysterectomy requires some different measures, and since this surgery may be performed only rarely, a long time may be required for surgeons to become accustomed to performing laparoscopic peripartum hysterectomy and the number of patients benefiting from it may be small.

Arendas et al. concluded that “a laparoscopic approach may be considered for delayed surgical management of abnormal placentation.” Of course, a laparoscopic approach may be considered, depending on the situation of the institution. However, the number one priority is to identify which strategy (Caesarean hysterectomy, delayed hysterectomy, or conserving management) is the best. Discussion of laparoscopic versus open surgery is the next step. While doing so, it is important to consider that at many institutions, even in developed countries, nighttime surgery is a challenging situation. Thus, although I applaud the authors’ pioneering effort, I believe that it may be too early or even dangerous to generally employ delayed laparoscopic hysterectomy in women with PPA.

**References**


**In Response**

**To the Editor:**

We would like to thank Professor Matsubara for his interest in our case report describing a delayed hysterectomy for placenta increta. In addition, we appreciate this important dialogue, which also includes his previous comments regarding the risks of delayed hysterectomy.

With respect to the specific questions regarding our case report, we would like to clarify a few issues:

1. There was no placenta previa in this case. As noted in our article, we were dealing with an invasive placenta (increta) only.

2. The initial plan in this patient’s care was actually a planned Caesarean hysterectomy. However, the patient came in on a weekend, and our colleagues elected to leave the uterus with the placenta attached to minimize the risk to the patient. As Professor Matsubara mentions, hysterectomy in these cases requires experienced surgeons and staff, ideally during a weekday when all hospital resources may be accessed. This was not the case at the time this patient presented. The risk of performing a hysterectomy at the time of Caesarean was felt to be unsafe and unpredictable. I applaud my colleagues for moving forward with this option. Often surgeons feel compelled to work outside their comfort level or surgical expertise, but in this case they made a wise and safe decision.

3. A delayed hysterectomy was planned in order to safely remove the uterus after six weeks to allow for maternal recovery and involution of the pregnant uterus. The patient was followed closely and the earlier laparoscopic hysterectomy was done when the patient presented with mild symptoms to avoid more complicated outcomes (e.g., sepsis, hemorrhage).

4. At our institution, for the last three years, we have had a surgical obstetrics team that deals with complex...