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Angelo Hooker[1]

[1]Zaans Medical Center (ZMC)

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Prevention, the way to go.

Angelo B. Hooker, M.D., Ph.D.

Zaans Medical Center (ZMC),

Department of Obstetrics and Gynaecology

Koningin julianaplein 58. P.O. Box 210.

1500 EE Zaandam, the Netherlands.

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Intrauterine adhesions (IUAs), characterized by partial to complete obliteration of the uterine cavity and/or cervical canal, is one of the main reproductive system diseases with menstrual disturbances, cyclic pain and reproductive disorder as the main clinical manifestations (Deans et al. *J Minim Invasive Gynecol* 2010;17:555–69). Hysteroscopic adhesiolysis (HA) is the standard treatment to improved menstrual pattern and reproductive performance.

Xiaocui and co-workers conducted a retrospective matched control study; women with a history of HA were categorized as exposed and women without as controls. The potential impact of age, parity, mode of conception, prior history of abortion and BMI were eliminated as exposed women were matched with four controls by propensity score matching. Ultimately, 780 exposed and 3010 matched control pregnancies were analyzed. Women with a history of HA had a higher risk for developing pre-eclampsia, there was an increased risk for placenta accreta spectrum and previa, postpartum hemorrhage and preterm birth. There was no association with newborn birth weights. The risk of obstetrical complications increased with the number of hysteroscopic interventions.

IUAs formation is multifactorial with multiple predisposing and causal factors. In up to 91% pregnancy-related intrauterine surgery is the predisposing risk factor (Schenker et al. *Fertil Steril*1982;37:593–610). The formation of IUAs seems to be the ultimate result of an abnormal response to inflammation leading to a defective endometrium with substandard vascularization by disruption of the basal layer (Saed et al. *Fertil Steril* 2002;78:137–43). The development of IUAs is still poorly understood but IUAs have an impact on female reproduction, adversely affecting reproductive and obstetric outcomes. IUAs has a debilitating impact on quality of life.

Although this retrospective registry-based study has a large sample size, important data could not be retrieved due to data inaccessibility. The number of prior abortions are reported but the number and type of intrauterine interventions, classification of IUAs and adjuvant treatment following HA, could not be assessed: crucial factors in the interpretation of the results. Moreover, the use of propensity score matching increases the risk of initial selection bias. Despite, Xiaocui et al. must be complimented for the way they conducting

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this study and the comprehensive assessment of potential confounders. The results of this cohort study are clinical relevant.

Prevention was not mentioned in the current study. The current treatment methods for IUAs are not optimal, the reproductive and obstetric outcomes remain limited and inefficient compared to women without IUAs, even after adhesiolysis. Prevention is essential and starts with preserving the basal layer of the endometrium and residing stem cells by preventing trauma. Intrauterine interventions should be prevented as much as possible and when there is a necessity, surgery should be performed in the gentlest manner, avoiding unnecessary trauma. Adhesion formation and the increased risk of adverse obstetric outcomes should be taken into account when treatment options are discussed. The more intrauterine interventions there are, the more destruction of the endometrium there will be. Prevention is crucial and the way to go.

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