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Reply: Ovarian suspension for longer than 36 h is necessary for temporary ovarian suspension to fulfil its remit

Sir,

We are grateful to Trehan and Trehan for their comments. We did consider suspending the ovaries following laparoscopic surgery for longer than 36 h. However, we had experienced a case of acute small bowel obstruction following a similar suspension procedure which required immediate release of the suspension suture (data on file). This is a very distressing and potentially serious complication and we did not feel that it would have been safe to discharge women home with the ovarian suspension suture in situ. We have decided to adopt a 36 h interval based on a methodologically robust study which used an animal model to show that susceptibility for adhesion formation was significantly reduced or eliminated after the first 36 h following a peritoneal injury. This was a relatively recent study, whilst all the other animal studies quoted by Trehan and Trehan were published almost four decades ago.

We were interested to learn that Trehan and Trehan have introduced post-operative ovarian suspension for 5–7 days into their routine clinical practice. We could not find any publications authored by them or by anyone else describing the efficacy of this approach. In view of that we would urge our colleagues to consider publishing their data in order to help others to learn from their unique experience.

A second look laparoscopy for the outcome evaluation of the trial has its benefits; however, even in their own publication, they did not report on outcomes because a repeat laparoscopy could not be justified for ethical reasons (Trehan, 2002).

Reference


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Uterine artery embolization for severe symptomatic fibroids: effects on fertility and symptoms

Sir,

We read with interest the paper by Torre et al. (2014) but would like to raise a number of concerns. They conclude that uterine artery embolization (UAE) should not be offered to women of reproductive age as it could be detrimental to their fertility prospects. We strongly contend that the only legitimate conclusion they could reach from the data obtained from their study cohort is that UAE does not improve fertility prospects in women whose prospects were, at best, dismal, while the treatment significantly improved their symptoms.

Torre et al. studied a relatively small (for purposes of fertility outcomes) cohort of women with extensive fibroid disease, the majority of whom had had previous surgical interventions, and for whom further, or de novo, surgical intervention was either refused or advised against. These women were symptomatic and for that alone they needed some form of intervention. Implicit in the way the paper is