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# Preservation of the uterus

*Dear Editor*

We were interested in reading the report from Dr Alkış and colleagues [1], entitled "The fertility sparing management of postpartum hemorrhage: A series of 47 cases of Bakri balloon tamponade", which was published in the June issue of the *Taiwanese Journal of Obstetrics and Gynecology* this year. The authors performed a retrospective study to evaluate 47 women complicated with severe postpartum hemorrhage (PPH). The authors used the Bakri balloon tamponade (BBT) as a tool to manage these patients. Results showed that the outcome was excellent, with a high success rate up to 91.4%; therefore, the authors concluded that BBT is an effective, easy to use, and safe procedure for severe PPH [1]. We congratulated the success of this publication. In fact, use of the BT is not only successfully applied to women with PPH, as shown by the authors [1], but also functions as one of the best choices in the management of other pregnancy-related hemorrhages, such as severe postabortion hemorrhage [2]. The application of BT can prevent the use of more invasive and/or destructive procedures, and of most importance, the uterus can be preserved. However, we found that there are some unclear parts in the publication by Alkış et al [1], and we hope that Dr Alkış and colleagues could respond to our comments.

First, in terms of the basic characteristics of the enrolled patients, > 85% underwent Cesarean section (CS) and some of them had a high risk for PPH, such as abnormal placentation (especially placenta previa, and possibly placenta increta, percreta). Since these patients were at risk of PPH, did the authors ever consider any strategy preoperatively for these patients? There are a handful of articles available for this part. For example, in the April issue of the *Taiwanese Journal of Obstetrics and Gynecology*, two articles have shown that the use of preoperative and/or predelivery embolization might be a good alternative [3,4]. In addition, a similar strategy such as iliac vessel or uterine vessel ligation might also be considered as an alternative. What is the opinion of the authors about these strategies before and during CS for these high-risk women? Our experience showed that uterine artery ligation appears to be a promising method for treating pregnant women with uterine leiomyomas who are undergoing CS, because it is able to reduce postpartum blood loss and minimize the necessity of future surgery [5].

Second, could the authors comment on when was a good point to perform the BBT procedure? Could the authors kindly provide the data of the interval between occurrence of PPH and insertion of BBT? Did any difference present between CS and normal vaginal surgery? Furthermore, in Table 1 of the Dr. Alkış article [1], was blood loss only calculated by blood volume after delivery (PPH) or did this include the intraoperative blood loss during CS or vaginal delivery?

Third, before the insertion of BBT, what strategy did the authors suggest? Did the authors comment on any difference among the various causes of PPH? We only found the following situations, such as surgical repair of the laceration wounds of the cervix and lower genital tract; curettage of retained placental product; and use of uterotonics for uterine atony, reported by the authors [1]. We believe that the strategy for those pregnant women with a high risk of PPH who plan delivery is important.

Fourth, what was the median time between failure of the attempt to stop bleeding and the use of BBT? Was there any difference between CS and normal vaginal surgery?

Our comments do not argue the excellent works of Dr Alkış and colleagues. We would like to know how to apply this useful procedure to similar situations in the future. We believe that a prompt and better decision produce a different outcome. We totally agree that uterus sparing surgery and/or fertility sparing is of paramount importance; however, an earlier application of effective tools, and a well-trained team might offer the best chance of making the dream true.

## Conflicts of interest

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

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