Factor V Leiden and recurrent miscarriage

Dear Sir,

We read with interest the article by Rai and colleagues concerning the prospective outcome of untreated pregnancies in patients with factor V Leiden mutation and recurrent miscarriages (Rai et al., 2002). Rai and colleagues should be congratulated for their skilful evaluation of their data, showing a significantly lower live birth rate amongst women carrying the factor V allele (37.5%) compared with those of a normal genotype (69.3%).

However, a few questions have to be put forward. As the authors state that the women in the control group, ‘Did not receive pharmacological treatment except for folic acid’ during pregnancy, it would have been of interest to know what the underlying pathologies (if any) had been causing more than two recurrent miscarriages before this observed pregnancy. Otherwise these patients have to be considered as idiopathic recurrent aborters.

Some authors have linked endocrine disorders such as hyperprolactinaemia (Hirahara et al., 1998), hypothyroidism (Abalovich et al., 2002) and a status of hyperandrogenaemia (Bussen et al., 1999) to pregnancy complications or recurrent miscarriages. It would have been of interest if there were any significant differences with regard to these pathologies between both groups of patients.

Furthermore, it remains to be elucidated if any other thrombophilic changes, also carrying a risk for abortions, such as decreased factor XII activity (Braulke et al., 1993; Ogasawara et al., 2001; Inunuma et al., 2002) or hyperhomocysteinemia (Nelen et al., 2000) have been detected in patients of either group. The prevalence of combined thrombophilic defects (Sarig et al., 2002) would be of interest in the group of patients who carry the factor V Leiden allele. Since, for example, Martinelli et al. described an increased risk for thrombosis in pregnant patients with double heterozygous factor V and prothrombin gene mutations (Martinelli et al., 2001), one might assume that such a double mutation might also have an impact on the occurrence of placental malperfusion.

In addition, the numbers in the Abstract do not match: early miscarriage: n = 19, late miscarriage: n = 9, total number 28, compared with 25 as stated by the authors.

References


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Dear Sir,

All women attending the St Mary’s Hospital Recurrent Miscarriage Clinic are investigated according to our published protocol (Clifford et al., 1994) which is also described in the Methods section of our manuscript. No cause to account for their pregnancy losses was identified and the only difference between the two groups of women was in Factor V Leiden status.

We agree with Bohlmann et al. that the role of other thrombophilic defects and adverse pregnancy outcome at all gestational ages deserves further investigation. This is a field that we ourselves are actively pursuing and in particular we are examining the role of the fetal genotype in determining pregnancy outcome.

There is a typographical error in the Abstract. The number of women with recurrent early miscarriage is 16 and not 19 as stated in the Abstract. This error is not repeated elsewhere in our manuscript and all analyses were performed correctly.

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References

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