Editor—I have read with interest the article by Mercier and colleagues regarding the use of 6% HES (Hydroxyethyl starch) vs Ringer’s lactate for fluid preloading before spinal anaesthesia for Caesarean delivery. The study showed that the use of 6% HES plus Ringer’s lactate for preloading these women, significantly improved the prevention of both hypotension and symptomatic hypotension (hypotension plus nausea and vomiting and/or dizziness).

However, the recent studies in the use of HES and crystalloids solutions have shown that HES solutions significantly increase the risk of mortality and renal failure, in patients with sepsis and burns. Moreover, the European Medicines Agency’s Pharmacovigilance Risk Assessment Committee (PRAC) has concluded, following a review of the available evidence, that the benefits of infusion solutions containing HES no longer outweigh their risks and they have therefore recommended that the marketing authorizations for these medicines be suspended.

In our tertiary centre we routinely use a combination of Hartman’s solution (1000 ml) and phenylephrine infusion to prevent hypotension following subarachnoid block for elective Caesarean sections. I believe with the current restrictions of the use of HES solutions and the presence of safer alternatives (the crystalloids) it may be difficult to justify the use of HES solutions routinely in obstetric practice.

Declaration of interest
None declared.

References

Reply from the authors
6% Hydroxyethyl starch (130/0.4) vs Ringer’s lactate preloading before spinal anaesthesia for Caesarean delivery

F. J. Mercier
Clamart, France
E-mail: frederic.mercier@abc.aphp.fr

Editor—Thank you for your interest in our study. Your main point focuses on current restrictions in the use of HES and therefore applicability of our study results. As you pointed out, evidence against HES use arises from studies performed in critically ill patients including sepsis, a condition that is far different from healthy parturients undergoing scheduled Caesarean delivery. This obstetric specific situation is discussed in detail in our article, and positive or negative safety data reported in the non-obstetric setting may not be valid, in cases for Caesarean delivery. In addition, the last large multinational randomized study on use of colloids (predominantly HES), compared with crystalloids for fluid resuscitation in ICU patients (CRISTAL study, 2857 patients), did not report any colloid-related increase in renal failure nor in 28-day mortality. Instead, it suggested that 90-day mortality was lower among patients receiving colloids, although the authors stated cautiously this latter finding should be considered exploratory.

You also quoted ‘PRAC has recommended that the marketing authorisations for these medicines be suspended’. This does not accurately reflect as the last recommendation that was endorsed in December 19, 2013. Indeed, it was concluded that ‘HES solutions must no longer be used in patients with sepsis, burn injuries or critically ill patients’. However, it was added ‘HES solutions should only be used for the treatment of hypovolaemia due to acute blood loss when crystalloids alone are not considered sufficient . . . and used at the lowest effective dose for the shortest period of time’. Thus, HES use has been restricted but not ‘suspended’. And spinal hypotension during Caesarean delivery is indeed a setting with both (significant) hypovolaemia (because of acute vasodilation) ‘where crystalloids alone might not be sufficient’ and with a ‘use of the lowest effective dose for the shortest period’ (0.5–1 litre, just once).

Your last point was about the availability of (safer) alternatives to HES preloading (the crystalloids), that would make it