Sir,

We are pleased that Professor Barnhart acknowledges that the algorithms currently used to define viability in the pregnancy of unknown location (PUL) population are flawed.

It seems to us that there are three major issues that need to be considered in relation to this subject:

(i) How do we define a change in serum human chorionic gonadotrophin (hCG) that categorically defines a non-viable PUL?

(ii) Does diagnostic delay of a potential ectopic pregnancy in a PUL lead to harm because of rupture?

(iii) In how many women is it reasonable to perform an unnecessary uterine curettage in the PUL population?

In his letter, Barnhart acknowledges that more conservative definitions of non-viability in the PUL population should be adopted. Both Barnhart and we have shown that if uterine curettage is used in the management of PUL, the chances of interrupting a potentially viable intrauterine pregnancy can be reduced to <1% (Condous et al., 2006a; Seeber et al., 2006).

However, using such hCG ratio (hCG 48 h/hCG 0 h) threshold levels still results in the majority of women requiring uterine curettage.

In previous studies, we have shown that the conservative management of PULs is safe and effective (Condous et al., 2004, 2005a,b,c, 2006a,b; Kirk et al., 2006; Gevaert et al., 2006). Over 1000 PULs have been included in these published data and we have had no adverse outcomes in this population using this approach. The principle argument in favour of uterine curettage is that it shortens the time required to locate the pregnancy. However, our data suggest that in the majority of ectopic pregnancy cases, the final outcome is known by day 7 as the adnexal mass can be visualized using ultrasound. Therefore, potential diagnostic delay at this very early stage of pregnancy does not have an impact on the morbidity or mortality in the ectopic pregnancy subgroup.

Given the knowledge that uterine curettage, if not carefully used, may lead to an inadvertent termination of pregnancy, and that conservative management of PUL is both safe and leads to a known outcome within 7 days, it is difficult for us to understand why Barnhart continues to advocate the routine use of uterine curettage in these women. Where we agree is in the specific instance of persisting PUL. This is defined as a PUL in which serum hCG levels have plateaued and where no pregnancy was seen on transvaginal ultradound (TVS) at any time. These may either represent persistent intrauterine trophoblast or missed ectopic pregnancies on TVS. Uterine curettage in these cases may be helpful in locating the pregnancy and avoid the unnecessary administration of methotrexate.

While acknowledging Barnhart’s view, we feel that on the basis of our data, we must stand by our assertion that uterine curettage has no role in the routine diagnostic workup of women with a PUL. We understand that our view may not be universally accepted. However, if our paper leads to a re-examination of the protocols currently used to define the use of uterine curettage in the PUL population and, in particular, those advocated by the American Society for Reproductive Medicine (ASRM), we feel this would be a stepforward. Currently, there is little doubt that in a number of cases, women are undergoing unnecessary surgical intervention and on occasion potentially viable pregnancies are still being terminated in this group of women.

References


George Condous1,3, Emma Kirk2 and Tom Bourne2

1Early Pregnancy and Advanced Endosurgery Unit, Nepean Clinical School, University of Sydney, Nepean Hospital, Sydney, Australia and
2Early Pregnancy, Gynaecological Ultrasound and MAS Unit, Department of Obstetrics and Gynaecology, St. George’s University of London, London, United Kingdom.

3To whom correspondence should be addressed at: Early Pregnancy and Advanced Endosurgery Unit, Nepean Clinical School, University of Sydney, Nepean Hospital, Sydney, Australia. E-mail: gcondous@hotmail.com

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