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* As compared to conventional fluid management systems currently on the market.

FLUENT®
Fluid Management System



Something old, something new and something borrowed

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Linked article: This is a mini commentary on M-M Chou et al. To view this article visit <https://doi.org/10.1111/1471-0528.16605>

Surgical management of placenta accreta spectrum (PAS) is, if anything, wrought with complexity. Placental invasion can be confined and relatively easy to manage or as surgically challenging as a stage-IV ovarian tumour. In the most extensive cases, the placenta is equally capable of encasing not only the ureter but also the femoral vessels and obturator nerve, but instead of a solid tumour the surgeon is faced with a mixed solid–cystic structure that behaves like a large arteriovenous fistula until the blood supply from the uterine arteries and collaterals from the bladder is controlled. Even the well-intended, experienced vascular surgeon who has never encountered PAS risks inadvertently inciting haemorrhage, should he or she attempt to move the placenta to gain better exposure of the underlying vascular structures. We PAS surgical veterans will, therefore, always welcome effective tools and techniques targeted against massive haemorrhage.

In this edition of *BJOG*, MM Chou and colleagues report outcomes from their case series of 32 women in whom they prophylactically isolate and cross-clamp the

aorta (*BJOG* 2021; <https://doi.org/10.1111/1471-0528.16605>). Aortic occlusion has been an essential step in cardiovascular and trauma surgery for decades. Without it, abdominal aortic aneurysm repair and heart transplants would be impossible. Although this technique itself may not be entirely novel, this article adds to the growing body of evidence that patients benefit when we learn from expertise outside of our own disciplines. The surgical complexity and heterogeneity of PAS demands a multidisciplinary collaborative approach, not only to advance our understanding but ultimately to save women's lives.

Recently, there has been an evidence-based shift away from prophylactic occlusion of the internal iliac arteries towards an interest in more proximal arteries. Within the trauma and vascular surgery communities, significant debate continues between experts who trust vascular occlusion under direct vision and those who prefer intravascular techniques. The purpose of this mini commentary is not to espouse one method over another, but rather to highlight what remains unknown, and the questions that we must strive to answer. Is one

method of vascular occlusion superior over the other? What risks accompany each approach and how do we avoid iatrogenic harm? If median blood loss at surgery is being driven downwards with meticulous surgical techniques, do we risk more harm than good with prophylactic vascular occlusion?

Fortunately, MM Chou and colleagues had few complications with their technique. We caution against eager adoption without forethought, however: novel approaches are readily published but often without what surgeons need most, i.e., the details about the challenges and pitfalls encountered as the authors perfected their techniques, and how to avoid these obstacles. Specifically, we encourage obstetricians to rely upon the wisdom of the vascular surgeon when dissecting out the aorta. A rent in the adjacent thin-walled inferior vena cava (IVC) is more difficult to repair than the muscular aorta. Similarly, vascular surgeons are wise to heed the obstetrician who asks them not to disturb the placenta for the sake of exposure, as removing it can open the haemorrhagic floodgates. There is no doubt, however, that in the face of massive haemorrhage

temporary occlusion of the aorta, either digitally or with a 'swab on a stick', can be lifesaving.

Importantly, whatever method of vascular occlusion is favoured, what we most desperately need is objective data to help reduce potential ischaemic/reperfusion injuries and postoperative thromboembolism. We hope that this article serves not merely as a report of a single technique but as a springboard to foster collaboration and innovation, and to launch well-designed, high-quality, comparative

studies specific to complex obstetrical surgery and peripartum haemorrhage.

Disclosure of interests

SC has nothing to disclose. KF reports grants from the Eunice Kennedy Shriver National Institute of Child Health and Human Development, outside of the submitted work. In addition, KF is a local principal investigator for a multicentre database to review the risk and efficacy of the REBOA (resuscitative

endovascular balloon occlusion of the aorta) catheter. Completed disclosure of interest forms are available to view online as supporting information.

Supporting Information

Additional supporting information may be found online in the Supporting Information section at the end of the article. ■