TO THE EDITORS: Rozenberg and colleagues 1 reported that 17-hydroxyprogesterone caproate (17Pc) (500 mg twice/wk) did not significantly increase time to delivery or improve neonatal outcome when used as maintenance therapy after an episode of preterm labor. We would ask the authors to disclose the source of the drug and to clarify whether there was any testing to assure its quality. This is critical because of questions about the purity and potency of some 17Pc preparations available on the global market.

In a recent report, 2 chemical analysis was performed on 40 samples of 17Pc obtained from various sources throughout the United States, including 10 samples of active pharmaceutical ingredient (API) (the powdered raw ingredient) and 30 samples of compounded drug (API mixed with oil by compounding pharmacies). Of the API samples, 7 were traced to manufacturers in Asia that are not registered with or regulated by the US Food and Drug Administration (FDA); in other cases, the drug had been repackaged by distributors and the manufacturer could not be positively identified. One of the 10 API samples contained only glucose and no progesterone of any kind. Two thirds of the compounded samples failed analytical testing, either because of subpotency or superpotency exceeding US Pharmacopeia standards and/or unknown contaminants exceeding FDA standards.

These findings cast doubt on the results of any studies that used compounded 17Pc unless there was testing of purity and potency, especially studies that found no significant differences between 17Pc and control groups.

For the record, we would like to clarify that the 17Pc used in our recent trials of twin 3 and triplet 4 pregnancies was not a compounded drug but was manufactured according to current Good Manufacturing Practices. The API was made by an FDA-regulated manufacturer with an active FDA Drug Master File and prepared by another FDA-regulated manufacturer as specified in an FDA Investigational New Drug approval. An aliquot from each lot of prepared drug was sent to an independent laboratory to test for potency, purity, and sterility. Concentration was retested annually to assure stability. All 17Pc used for these trials met FDA specifications. Thus, we are confident in our conclusion that prophylactic 17Pc (250 mg weekly) is not effective for prolonging unselected twin and triplet pregnancies.

C. Andrew Combs, MD
Center for Research, Education, and Quality
Obstetrix Medical Group
900 E. Hamilton Ave. #220
Campbell, CA 95008
Andrew_combs@obstetrix.com

Kimberly Maurel, MSN
Center for Research, Education, and Quality
Obstetrix Medical Group, Mednax Inc, Sunrise, FL

REFERENCES

REPLY
We would like to thank Dr Combs and colleagues for their comments regarding our recent article entitled “Prevention of preterm delivery after successful tocolysis in preterm labor by 17 alpha-hydroxyprogesterone caproate: a randomized controlled trial.”

We are happy to clarify that the 17 alpha-hydroxyprogesterone caproate (17P) used in our trial was Progestéron Retard Pharlon licensed by the French Food and Drugs Administration and marketed in France since 1958. The drug is currently manufactured by Bayer Santé, which produces it in Germany in accordance with the detailed guidelines for starting materials established in part II of the European Union Good Manufacturing Practices. The manufacturer of the active substance is included in Bayer Santé’s audit program. Progestéron Retard Pharlon is the only 17P commercially available in France.

Therefore, the absence of significant differences between 17P and control groups in our study cannot be explained by the use of 17P of questionable quality. We are thus confident in our negative conclusion that 17P is not useful after arrested preterm labor.

Finally, it is interesting to note that the same 17P approved by the US Food and Drug Administration and marketed in the United States from 1956 through 2000 under the trade name of Delalutin was withdrawn from the market at the request of the
manufacturer for reasons unrelated to safety. Still more interesting is that on Feb. 15, 2011, KV Pharmaceutical announced the price of Makena at $1500 per injection, while the price of Progestérone Retard Pharlon in France is €3.32 per injection.

Patrick Rozenberg, MD
Department of Obstetrics and Gynecology
Poissy-Saint Germain Hospital
Versailles-St Quentin University
Rue du Champ Gaillard
78303 Poissy Cedex, France
prozenberg@chi-poissy-st-germain.fr

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TO THE EDITORS: I read with interest the paper entitled “Cost minimization analysis of laparoscopic sacral colpopexy and total vaginal mesh” by Drs Christopher F. Maher and Luke B. Connelly.1 The paper focused on cost containment for the treatment of uterine prolapse. I noticed that the authors considered laparoscopy vs the total mesh vaginal approach. This very well-done study did not mention the inexpensive minilaparotomy approach.

I presented the minilaparotomy approach for sacral cervicopexy2 followed by a slide presentation online (ObGyn.net) entitled “Surgical treatment of uterine procidentia” under the auspices of the American Association of Gynecologic Laparoscopists 33rd annual meeting in November 2004.

I used an elastic retractor placed inside the abdomen through a 5-cm transverse suprapubic incision. Exposure of the sacral peritoneum is easy to accomplish as the prolapsed uterus is not blocking the view. The peritoneum in front of the promontory is open; a suture is placed in the promontory ligament and tested for its holding strength. Supravaginal hysterectomy is then performed.3 Prior to the amputation, the fundus of the uterus is pulled upward and anterior to aid in the next step of the cul-de-sac obliteration. A polypropylene hammock is threaded using the previously placed sutures and tied at the promontory. This is followed by amputation of the uterus and ablation of the endocervical canal. The hammock caudal end is tied at the cervical stump near the uterosacral ligaments. The cervical stump and the hammock are covered with peritoneum. The parietal peritoneum is closed and the elastic retractor is removed. The incision gives sufficient exposure to perform the Burch procedure.4

The technique was successfully used with minor modifications by Dr Martin Castillo Mendoza from Peru,5 Dr Vicente Sola et al from Chile,6 and Dr Alan D. Garely from the United States.7 I agreed with the authors of this fine article that “it is now imperative that clinicians include dollar cost of surgical interventions as a vital part of our decision making process.” Minilaparotomy is a reproducible, efficient, and inexpensive minimal access surgery for the treatment of uterine prolapse that does not compromise quality or results.

Daniel A. Tsin, MD
Mount Sinai Hospital of Queens
25-10 30th Ave.
Long Island City, NY 11102
Lasergyn@aol.com

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REFERENCES

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REPLY

We thank Dr Tsin for his letter to the editor outlining the surgical technique of the minilaparotomy approach to sacral cervicopexy for uterine procidentia. Clearly, uterine procidentia is an important and fertile area of research; however, our trial evaluated only those with posthysterectomy vaginal vault prolapse.