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CORRESPONDENCE

# Answer to the editor

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Dear Editor

Thank you very much for inviting us to answer the careful comments by Dr. Coccia and Dr. Rizzello. Indeed our evaluation indicated that the repeated miscarriages may resemble an underlying problem of infertility. This observation leads us to the final conclusion that the prevention of recurrent miscarriages (as a clinical entity) may be more appropriate than its treatment. We do not generally advocate expectant management after recurrent miscarriages.

Instead, we recommend to keep an eye on couples from their first failed pregnancy on, and to screen and counsel them on possible factors which may reduce their fertility. This can be, e.g., lifestyle factors (such as nicotine habits or elevated BMI), diabetes, andrological, or tubal factors. After an evaluation has been undertaken—as far as individually advisable—the next pregnancy should not be delayed for too long.

Therefore, we perfectly agree that maintaining fertility is a very important issue after miscarriage. In our view, this may also apply for the decision for or against dilatation and curettage. Surgical evacuation may be replaced by expectant management in certain cases with the womańs consent [1, 2]. Accordingly, surgical treatments of unproven value ("endometrial scratching" prior to IVF or ICSI embryo transfer) should be weighed with much caution. Data on prognosis may help to encourage couples who have conceived spontaneously so far to decide for another pregnancy. We agree that especially those who are at higher risks not to achieve a further pregnancy spontaneously (e.g., women 35 years and older, those having had a prolonged waiting time or more than three miscarriages) are candidates to be referred to a fertility clinic.

In their retrospective observational cohort study on 299 women [3], Dr. Coccia, Dr. Rizzello, and coworkers described that recurrent pregnancy losses occur at similar gestational ages as the preceding loss. Based on our findings, we would expect that the group of patients with predominantly clinical first trimester losses had a favourable outcome, as compared to those with mainly early preclinical losses or losses of unknown location. Within their group of women who suffered clinical miscarriages, subgroups may be identified who may have an excellent prognosis concerning pregnancy and delivery without requiring infertility treatment. It would be exciting to learn which progress the participants of their study actually have made.

**Compliance with ethical standards**

**Conflict of interest** None.

## References

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