Elsevier has created a Monkeypox Information Center in response to the declared public health emergency of international concern, with free information in English on the monkeypox virus. The Monkeypox Information Center is hosted on Elsevier Connect, the company's public news and information website.

Elsevier hereby grants permission to make all its monkeypox related research that is available on the Monkeypox Information Center - including this research content - immediately available in publicly funded repositories, with rights for unrestricted research re-use and analyses in any form or by any means with acknowledgement of the original source. These permissions are granted for free by Elsevier for as long as the Monkeypox Information Center remains active.

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Approach to monkeypox in pregnancy: conjecture is best guided by evidence

Check for updates

We welcome Mungmunpuntipantip and colleagues' thoughts on the management of monkeypox during pregnancy. Their comments reiterate the consensus that monkeypox is a reemerging zoonosis of global health concern, not least for high-risk populations. However, the authors presented several points that require clarification.

First, although skin lesions may be discreet, the most common symptom in the ongoing monkeypox outbreak remains the appearance of rash (systemic, oral, genital, or in other locations) in 16,954 of 20,183 laboratory-confirmed cases (84%) reported to the World Health Organization (WHO).[1] Therefore, a careful clinical examination evaluating epidemiologic circumstances and mucocutaneous sites is crucial should obstetricians encounter a patient with nonspecific symptoms. Although there are reports of asymptomatic viral shedding in gay men, the actual prevalence is presently unknown, and the number who subsequently develop lesions is unclear. Data regarding the frequency of asymptomatic carriage of the monkeypox virus (MPXV) is necessary before the universal screening of pregnant women is recommended.

Second, as of September 15, 2022, gastrointestinal symptoms, including diarrhea and vomiting (as suggested by the authors), have not been recorded in the WHO's global surveillance report.[1] In addition, although the most common neurologic manifestation of monkeypox infection is a prodromal headache—usually generalized or frontal[2]—such headaches are common in pregnancy and many other systemic viral infections. Importantly, however, we advise obstetricians to recognize the onset of altered mental status, muscle weakness, and bladder and bowel incontinence as these are atypical features of MPXV infection, given reports of MPXV-associated encephalomyelitis in previously healthy, immunocompetent individuals.[3] The pathophysiology of such neurologic manifestations is likely to be either an MPXV invasion of the central nervous system or a parainfectious autoimmune process precipitated by MPXV viremia.

Third, the assessment and accreditation of laboratories performing MPXV polymerase chain reaction (PCR) assays are standard linchpins to avoid the authors' concerns of specimen contamination and inaccurate results.

Finally, we disagree with the statement that there is a negligible risk of vertical transmission of MPXV. Monkeypox viral DNA within fetal and placental lesions has been detected concurrently at birth with real-time PCR. More likely, the spurious shortage of clinical data results from the socioeconomic challenges restricting scientific publication within remote countries where monkeypox was previously endemic. Furthermore, it is uncontested that pregnant women with MPXV demonstrate a high rate of adverse outcomes, including pregnancy loss. Several pathogenic mechanisms could contribute to the intrauterine transmission of MPXV, including ascending infection, hematogenous dissemination, and direct infection of syncytiotrophoblasts.[4] The risks to the fetus must not be disregarded during this outbreak. ■

David Baud, PhD
Maternal-Fetal and Obstetrics Research Unit
Department of Women, Mother and Child
Lausanne University Hospital
Lausanne, Switzerland

Karin Nielsen-Saines, MD
Division of Pediatric Infectious Diseases
Department of Pediatrics
David Geffen School of Medicine at the University of California, Los Angeles
Los Angeles, CA

Pradip Dashraath, MRCOG
Division of Maternal-Fetal Medicine
Department of Obstetrics and Gynecology
National University Hospital
Singapore
Yong Loo Lin School of Medicine
National University of Singapore
Singapore
pradip_dashraath@nuhs.edu.sg

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Risk of endometrial cancer in asymptomatic postmenopausal women in relation to ultrasonographic endometrial thickness

Check for updates

TO THE EDITORS: We read with interest the review by Vitale et al.[1] The implication of this review is that the most important parameter in assessing the risk of endometrial cancer, which should lead to initiating invasive diagnostic procedures, is the endometrial thickness (ET), whether the cutoff may be 3 or 6 mm. The authors accept that there is no guideline for universal screening for endometrial cancer but imply that incidental screening at routine gynecologic examinations should be performed. In the author's meticulous statistical analysis of ET, they failed to include other risk factors, such as age, obesity, hormonal treatments, or family history. These data deficiencies restrict the value of a single ET measurement in clinical decision-making and in addressing very practical questions as follows: Does a 6-mm endometrial thickness in an 80-year-old woman carry the same risk as in a 55-year-old woman? What if the patient has the same ET measured over time? What is the success rate of office hysteroscopy in each age group? Should a failure of diagnostic hysteroscopy because of cervical stenosis invariably lead to hysteroscopy under general anesthesia? What if the patient has significant comorbidities? Should we advocate pursuing a procedure under general anesthesia knowing the low yield? Do we defer the procedure and leave the patient with fear that she has cancer? Most importantly, does early diagnosis of endometrial cancer in asymptomatic patients carry a better prognosis?

The authors have listed our study, which was further corroborated in a meta-analysis[2,3] in their reference list, but did not address our results and their implications. Endometrial cancer diagnosed in asymptomatic postmenopausal women was not found to be associated with higher survival rates than in patients with postmenopausal bleeding. We believe that operative hysteroscopy and curettage procedures should be very carefully considered in asymptomatic patients with ultrasonographically diagnosed endometrial polyps or thick endometrium. It is reasonable to reserve these procedures for patients whose ultrasonographic findings demonstrate marked change over time or for patients at very high risk of endometrial cancer. ■

Ofer Gemer
Department of Obstetrics and Gynecology
Barzilai Medical Center Ashkelon Israel
Affiliated to the Goldman Medical School
Ben-Gurion University
Beer Sheva, Israel

Ofer Lavie
Yakir Segev, MD, MSc
Department of Obstetrics and Gynecology
Carmel Medical Center
Affiliated to Technion
Israel Institute of Technology
Haifa, Israel
segevyakir@yahoo.com

The authors report no conflict of interest.

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