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Response to Gómez-Calero et al. concerning their comments on the article ''Prevalence and characteristics of gastroesophageal reflux disease in pregnant women''

Respuesta a Gómez-Calero et al. respecto a sus comentarios sobre el artículo ''Prevalencia y características de enfermedad por reflujo gastroesofágico en mujeres embarazadas''

Dear Editors,

We wish to thank Drs. Gómez and Jara for their insightful comments on our study ''Prevalence and characteristics of gastroesophageal reflux disease in pregnant women''. We appreciate the opportunity to discuss and clarify the concerns raised regarding our methodology.

One of the concerns expressed is the importance of physical activity in preventing gastroesophageal reflux disease (GERD) during pregnancy, noting that moderate-to-high physical activity levels could lower the risk of GERD. We acknowledge the association between physical activity and GERD risk. However, the impact of physical exercise on the risk of GERD varies, depending on the type and intensity of the activity. While moderate physical activity might have a protective effect,[1] vigorous exercise could exacerbate GERD symptoms by delaying gastric emptying.[2,3] Moreover, research specifically examining the protective role of physical activity against GERD during pregnancy is currently lacking. We recognize this gap in the literature and agree on the necessity for prospective studies in a controlled setting to explore safe and effective exercise regimens for pregnant women at risk of GERD.

Another concern is about the interplay between physical activity and obesity – a well-known risk factor for GERD. While increased waist circumference is recognized as a risk factor for reflux during pregnancy,[4] our previous research within this project indicated that pre-pregnancy body mass index (BMI) and current BMI had no significant association with GERD in pregnancy.[5] Furthermore, we observed that the prevalence of GERD increased in the third trimester, compared with earlier trimesters. These findings suggest that the mechanical effects of increased abdominal pressure from the enlarged uterus are more likely to contribute to the development of GERD than is obesity resulting from decreased physical activity during pregnancy. Consequently, even though obesity is a recognized risk factor for GERD in the general population, we believe it does not play a substantial role in the onset of reflux during pregnancy.

With respect to the concern raised about the influence of dietary habits on GERD during pregnancy, particularly the methodology related to data collection on dietary habits and their association with GERD, the primary aim of our study was to report the prevalence and clinical characteristics of GERD in pregnancy. Nevertheless, we *did* assess dietary habits, particularly focusing on meal patterns and timing, which were extensively detailed in a previous study.[5] In that research, we did not delve deeply into the specific types of foods consumed but focused on overall meal patterns and timing, particularly the short meal-to-bed time (MTBT), which we identified as a significant risk factor.[5] We recorded the main meal based on overall size and caloric density, as reported by participants, and defined a ''short'' MTBT as within two hours post-meal. For a detailed understanding of our dietary data collection and analysis methods, we invite readers to review the methodology section of that publication.

In conclusion, ongoing research involving pregnant women is essential to enhance our understanding of the factors associated with reflux in this vulnerable population. This will enable us to alleviate the burden of GERD, not only through medical interventions, but also by promoting lifestyle modifications to improve quality of life during pregnancy.

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Periprocedural and perioperative anticoagulation management strategies in liver cirrhosis

Estrategias de manejo perioperatorio y periprocedimiento de la anticoagulación en la cirrosis hepática

Dear Editors,

We have read the consensus statement by Velarde-Ruiz Velasco et al.[1] with great interest and would like to share the following thoughts and questions. It is important to emphasize that there is a significant prevalence of comorbid cardiovascular conditions, such as non-valvular atrial fibrillation, venous thromboembolism, and splanchnic venous thromboembolism of 5%, 7%, and up to 24%, respectively, according to epidemiological data.[2] Moreover, in a cohort study conducted within the time frame of 2012 and 2019, the prescription and use of direct oral anticoagulants (DOACs) increased from 20 to 77%, showing a significant increase in prescription trends with DOACs in the liver cirrhosis population.[2]

Given the above, we strongly believe that special and meticulous care, in a multidisciplinary fashion (e.g., the inclusion of a hematologist or vascular medicine specialist with expertise in thrombosis and hemostasis) should be considered, and reasonable recommendations should be provided within the Velarde-Ruiz Velasco consensus paper,[1] not only for thromboprophylaxis, but also for patients currently taking DOACs for the abovementioned clinical cardiovascular indications. Recently, different medical societies have published clinical practice guidelines with their own recommendations regarding the perioperative and periprocedural management of diverse antithrombotic therapies, including DOACs and antiplatelet therapies. Such recommendations apply to our liver cirrhosis population.[3,4]

Importantly, Velarde-Ruiz Velasco et al.[1] failed to provide detailed recommendations on how to approach significant adverse effects of anticoagulants, including DOACs, such as the occurrence of major life-threatening bleeding events. This encompasses knowing the *what, when, which, and how*, when considering potential clinical indications for rapid and appropriate reversal strategies in a cirrhotic patient taking DOACs; for example, in the setting of intracranial bleeding, life-threatening GI bleeding with hemorrhagic shock, or the need of urgent/emergency surgical intervention that cannot be delayed (e.g. acute cholecystitis or appendicitis). How do the consensus authors tackle these challenging clinical scenarios? Would they consider nonspecific or specific reversal agents, like 4-factor prothrombin concentrates (4F-PCC) or andexanet alfa (AA)?[5] When should 4F-PCCs be considered over AA and vice versa? Does the high-risk baseline hypercoagulable/prothrombotic status of our patients (e.g. non-valvular atrial fibrillation with a CHA2DS2-VASc score > 7 points or recent severe venous thromboembolism within 90 days) need to be better screened or risk stratified, before making such tough decisions in a multidisciplinary manner? The International Society on Thrombosis and Haemostasis recently published an updated guidance document for DOAC reversal strategies.[5]

Lastly, Velarde-Ruiz Velasco et al.[1] recommended low molecular weight heparin over unfractionated heparin for thromboprophylaxis. We disagree with this recommendation, especially in clinical scenarios in which advanced chronic kidney disease (CKD stage 4 or 5 according to the KDIGO classification, defined by a GFR < 30 ml/min × 1.73 m^2) and advanced liver cirrhosis coexist (e.g. Child-Pugh class C or MELD score > 20 points). Furthermore, there is a scarcity of randomized, prospective data addressing these clinically relevant caveats.[6,7] We prefer unfractionated heparin due to its excretion through the reticuloendothelial system, including the liver, thus avoiding bioaccumulation and bleeding complications.

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Conflict of interest

The authors declare that there is no conflict of interest to disclose.

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