Reviewer's report

Title: Successful anti-disseminated intravascular coagulation therapy and vaginal delivery following intrauterine fetal death due to placental abruption: a case report

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Reviewer: Andrew Atkinson

Which of the following following best describes what type of case report this is?: Presentations, diagnoses and/or management of new and emerging diseases

Has the case been reported coherently?: Yes

Is the case report authentic?: Yes

Is the case report ethical?: Yes

Is there any missing information that you think must be added before publication?: Yes

Is this case worth reporting?: Yes

Is the case report persuasive?: Yes

Does the case report have explanatory value?: Yes

Does the case report have diagnostic value?: Yes

Will the case report make a difference to clinical practice?: Yes

Is the anonymity of the patient protected?: Yes

Comments to authors:

This is a case report on a very relevant topic today in Obstetrics. The manuscript is well written and you can tell that the authors took time in researching background information in preparation to write this paper.

This first question I have is why this patient was transported 2 hours and 30 minutes after being diagnosed with an abruption? As you demonstrate in your report, her abruption was 50%, but she had massive concealed bleeding that caused her to go into DIC. If the diagnosis was made and induction of labor would have been initiated from the time of diagnosis, she may not have gone into DIC. It was even suggested in your own words “if delivery is prolonged, DIC may
become more severe,” I am not sure if this patient was in a rural setting, or what the circumstances were, but I think this needs to be explained because for the reader it is very unclear.

Also to followup on question #1, was there labs drawn when the diagnosis of fetal demise/abruption was diagnosed? Was she in DIC then, or did it happen at a later time?

My second comment is… it is not typical to see a post-term abruption happen, placental abruption usually happens between 24 and 27 weeks. The authors really do not comment on if this patient had any risk factors or not to cause this to happen so late in her pregnancy…

My third comment is, the authors states that, the reason for proceeding with induction of labor, was because there was a lack of external hemorrhage…Im not sure about the lucid state the patient was in when she arrived to the referral center, but the reason induction proceeded was because the patient was stable as demonstrated by her vitals and labs….

At what point in the induction process, did her mental status improve?

As far as the method of induction, the authors state that they started pitocin at approximately 530am. By 9am effective contractions were still not seen and the pt was not in labor after 4 hours of being on pit, while she was progressing further into worsening DIC, my question is, why wasn’t amniotomy performed immediately? The patient arrived 3cm dilated, what was the delay? Induction should have been aggressive, especially with a dead fetus and active DIC…

Can you please explain why the uterus was packed if there was no heavy bleeding after delivery? Is this a routine maneuver that is performed at your institution? Usually if there is no heavy bleeding after delivery the uterus is left alone, and if there is bleeding later on, I would want to know about it, and not conceal it with packing. But if there was bleeding after delivery, please clarify this…

Overall I applaud the authors in the management of this patient. The report is also very well written, and the figures are very good. Small changes need to be made, but I do recommend this paper for publication. Thank you…

**Level of interest:** An article of importance in its field

**Quality of written English:** Acceptable

**Declaration of competing interests:**

The reviewer of this manuscript has no conflict of interest to report.