Examining the **EVIDENCE**

Has the evidence tipped in favor of delayed cord clamping?

Not yet. This review of 15 randomized trials found no significant differences in primary maternal and neonatal outcomes between early (≤60 seconds of delivery) and late (>1 minute after delivery) cord clamping.

McDonald SJ, Middleton P, Dowswell T, Morris PS. Effect of timing of umbilical cord clamping of term infants on maternal and neonatal outcomes. Cochrane Database Syst Rev. 2013;(7):CD004074. doi:10.1002/14651858.CD004074.pub3.

EXPERT COMMENTARY

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FAST TRACK

Because the data supporting delayed clamping are weak, a change in practice is not warranted

In December 2012, the American College of Obstetricians and Gynecologists (ACOG) published a Committee Opinion on the timing of umbilical cord clamping after birth, but it found insufficient evidence to recommend early or delayed clamping.[1]

In a Cochrane review published earlier this year, McDonald and colleagues reviewed 15 trials and 3,911 mother-infant pairs, exploring the primary outcomes of severe maternal postpartum hemorrhage (≥1,000 mL), maternal death, and severe maternal morbidity and neonatal death associated with early versus delayed clamping. They also analyzed a number of secondary outcomes. None of the primary outcomes reached statistical significance.

In a statement from the World Health Organization (WHO) included in the Cochrane review, it was recommended that "the cord should not be clamped earlier than necessary"; the WHO graded this as a "weak recommendation" based on "low-quality" evidence.

With such underwhelming evidence, I would guess that the average clinician does not feel very motivated to change his or her practice, if that practice involves early clamping.

One limitation of the Cochrane findings

In the studies included in the Cochrane review, there was marked heterogeneity in the definition of delayed cord clamping, which ranged from 1 minute after delivery to the complete cessation of cord pulsation (~5 minutes). Some of the studies even used alternate times (2 minutes, 3 minutes, and so on).

Delayed clamping improved neonatal hemoglobin status

Among the secondary outcomes assessed in this review was an improvement in neonatal

WHAT THIS EVIDENCE MEANS FOR PRACTICE

I recommend that obstetric care providers continue their current practice until more detailed data emerge on the risks and benefits of delayed clamping. If a patient asks about the issue, we should counsel her about the risks and benefits of early versus delayed clamping and comply with her choice when there are no contraindications.

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ON THE WEB

Dr. Repke tells how he counsels patients who ask about delayed clamping, at obgmanagement.com

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hemoglobin concentration and overall iron stores associated with delayed clamping—but this benefit came at the expense of a higher incidence of neonatal jaundice requiring phototherapy. As a result, the investigators concluded that delayed cord clamping should be performed when there is ready access to phototherapy.

Should we implement delayed clamping?

At this time, I am reluctant to recommend that we shift to delayed clamping. Here are my reasons:

- **Data are lacking** as to whether increased hemoglobin levels and iron stores in newborns improve outcomes—or provide any benefit. No long-term developmental outcome data were included in the Cochrane review.
- Although I am not a pediatrician, **I am unaware of infant iron deficiency being a significant threat to public health in the developed world.**
- **The greater need for phototherapy** in the delayed-clamping group should not be viewed as inconsequential.
- **Iron supplementation is probably more readily available than phototherapy,** especially in developing countries.
- **In the minority of cases in which delayed clamping might be beneficial (eg, prematurity), it is not always feasible,** as these infants may already be compromised. Anxious neonatologists generally want the newborn handed over to them for resuscitation as quickly as possible, generally frowning upon a delay of 3 to 5 minutes for the blood to move from the placenta to the infant.

Reference

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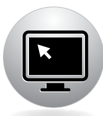

PRACTICE Management

Medical liability reform

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settled without any payment on behalf of the ObGyn.

Lots of state action

We need a federal solution, but since that isn't soon within reach, we're looking to the states for action. And there's a lot of action in some states, including Connecticut, Florida, Georgia, Hawaii, Illinois, Iowa, Missouri, Oregon, Rhode Island, Tennessee, and Utah.

Advocates in these states are trying a number of different approaches, hoping that some type of meaningful reform will be signed into law. (For specifics on actions within the states, see the Web version of this article at obgmanagement.com.)

Medical liability reform—the obvious need for it, the good reasons to carry it out, and the fact that it remains beyond our reach—is a constant source of frustration for many ObGyns. Maybe Captain Sullenberger can save the day.

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