"Safe use and enduring value of operative vaginal delivery," by Maeve Eogan, MD, and Colm O'Herlihy, MD (June)

Down but not out: Some of us still use forceps

It is reassuring to know there are still some advocates of appropriate operative vaginal delivery. I was trained to use forceps during my residency, and our teaching service had a forceps rate of approximately 21%, with a cesarean section rate of 18%. In contrast, our residents have an operative vaginal delivery rate of 4% to 5% and a C-section rate of 25%. Of course, many other variables have come into play, but less training and fear of litigation are 2 important factors.

I take issue only with the authors' comments about the Kielland forceps. Along with many of my colleagues, I was trained to use rotational forceps for a fetus in occiput transverse position that has not completed its descent. While the Kielland forceps is limited to this specific condition, I find them quite helpful.

As for episiotomy, I have not found a need for its routine use (much less for "large and early episiotomy") with the Kielland forceps or any other type of forceps. In fact, when I use forceps, I often bring the baby's head below crowning and, once I am able to effect a modified Ritgen maneuver, remove the blades and control the delivery manually.

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Lawyers to blame for demise of forceps

Finally, someone has stepped up to the plate with an article that explains the virtues of operative vaginal delivery. As one of those senior "skilled operators," I was always shocked to encounter physicians who had completed ObGyn residencies without ever performing a forceps delivery. Imagine an orthopod who has never handled a fracture, an anesthesiologist who never put anyone to sleep! The sorry thing is that the article is addressed not to first-year residents but to board-certified, working ObGyns! These doctors graduated from residency programs that lacked staff experienced in instrumental delivery and thus had no opportunity to learn technique, since forceps can only be learned with hands-on experience. Lawyers have been instrumental in killing this skill.

I want to contribute 2 minor additions to the article. First, there is nothing magical about a right mediolateral episiotomy. Right-handed doctors (most of us) simply find it easier to cut this type of episiotomy. Lefties can cut to the left with the same result. I preferred midline in all situations, but its use seems to vary geographically.

Second, I sometimes used the vacuum extractor in emergency situations when the head of a second twin was presenting, but high. Another strategy in this scenario is giving the mother a couple of whiffs of halothane (or other uterine relaxer), converting the vertex to a breech, and performing a breech extraction. Uterine relaxation is necessary for this—and Piper experience

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"Finally, someone has stepped up to the plate with an article explaining the virtues of operative vaginal delivery"

is nice, too! Note that conversion of the vertex to a breech should not be attempted with conduction anesthesia alone; you need an agent that relaxes the uterus. Since nobody has ether anymore, be prepared to use halothane (and insist that the anesthesiologist use what you want). The only other option is cesarean section.

I am afraid instrumental delivery is a lost art, and now, with elective cesarean, perhaps vaginal delivery itself will disappear. Another reason I am glad I limit my practice to gynecology.

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Dr. Eogan and Dr. O'Herlihy respond:

Training is decisive factor in operative vaginal delivery rates

We appreciate the positive comments of Doctors Friedman and Frischer. In regard to the Kielland forceps, we no longer use this instrument at our unit and thus have limited experience with it.

Our institutional incidence of operative vaginal birth was 12.7% in 2004, with a cesarean section rate of 17% in the same year. Were it not for safe and appropriate training in assisted vaginal delivery, our incidence of cesarean section undoubtedly would be higher. We postulate that the different rates of instrumental delivery, and correspondingly of second-stage cesarean, in the United States may be attributed to differences in residency training programs and trainer and trainee confidence rather than in significant population differences.

While cesarean section plays an important role in modern obstetrics, instrumental delivery remains a safe alternative in the second stage of labor provided its practitioners are appropriately trained.

"Is patient-choice primary cesarean rational?" by Geeta Sharma, MD (May)

Is "rational" cesarean a misnomer?

Let me get this concept of "rational" straight. A woman can choose a surgical procedure to terminate the life of her fetus, and this is considered rational by ACOG, the Supreme Court, and many Americans. When another woman chooses a surgical procedure to lessen the risk of mortality to her fetus during delivery, we need a national conference to decide if her decision is rational.

When a Jehovah's Witness goes through pregnancy and refuses transfusion, the mother's risk of death is 1 in 170.[1] This risk is similar to the maternal mortality rate in developing countries with no prenatal care.[2] Many physicians gladly take care of such patients and respect their choices. These physicians allow that such nonscientific beliefs are rational.

Let us differentiate between science and morals, science and marketing, science and religion. Science is rational and, at its best, not subject to cultural relativism. These other components of our everyday practice are suffused with value judgments, financial incentives, and beliefs not based on scientific merit. Patient-choice cesarean section, like the concept of the ideal cesarean-section rate,[3] is not a dilemma that will be solved by the tools of science.

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"Our everyday practice is suffused with value judgments, financial incentives, and beliefs not based on scientific merit"

REFERENCES

1. Singla AK, Lapinski RH, Berkowitz RL, et al. Are women who are Jehovah's Witnesses at risk of maternal death? Am J Obstet Gynecol. 2001;185:893–895.
2. World Health Organization. World Health Report 2005. Make every mother and child count. Geneva: WHO; 2005.
3. Cyr RM. Myth of the ideal cesarean section rate: commentary and historic perspective. Am J Obstet Gynecol. 2006;194:932–936.

Dr. Barbieri responds:

Many factors influence the cesarean decision

I thank Dr. Walsh for his concise critique of cesarean delivery on maternal request. His conceptual framework is very practical.

As he notes, medical decisions are heavily influenced by both scientific findings and "nonscientific" factors such as cultural context, subjective value judgments and non-conscious cognitive processes.