COMMENT & CONTROVERSY

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"Give a uterotonic routinely during the third stage of labor," by Robert L. Barbieri, MD (Editorial, May)

Uterotonic, yes, but have a sonogram on file

I agree with Dr. Barbieri's assertion that a uterotonic should be given routinely in the third stage of labor, but I recommend one very important proviso: A sonogram should be on file.

My advice comes from experience. I once took care of an unregistered patient who had not had prenatal care and who came in with cervical dilation to 8 cm and was progressing rapidly. After delivery, I did a digital exam and discovered an undiagnosed twin (vertex). Just think what would have happened if I had given a "routine bolus" of oxytocin!

I trained with people who gave oxytocin when the anterior shoulder was delivered. I have found that the cervix can close down very fast if the uterotonic is given after the baby is delivered but before placental delivery.

John Lewis, MD
Avon, Conn

Dr. Barbieri responds:

Uterotonic can wait until delivery of the placenta

I appreciate Dr. Lewis' astute clinical comments about administering a uterotonic at delivery, which are clearly based on significant clinical experience. In the case of multiple gestation, it is preferable to wait until both fetuses are born before giving a bolus of oxytocin. The undiagnosed multifetal gestation presents a significant challenge for the obstetrician.

Many clinicians have noted that administration of oxytocin after the delivery of the infant's anterior shoulder stimulates cervical contraction and may increase the rate of retained placenta. In response, these clinicians prefer to administer a uterotonic after delivery of the placenta. This practice is perfectly acceptable and has been demonstrated to reduce the risk of postpartum hemorrhage.[1]

Reference

1. Nordstrom L, Fogelstam K, Fridman G, Larsson A, Rydhstroem H. Routine oxytocin in the third stage of labour: a placebo controlled randomized trial. Br J Obstet Gynaecol. 1997;104:781–786.

"Administration of oxytocin after delivery of the infant's anterior shoulder stimulates cervical contraction and may increase the rate of retained placenta"

"Malpractice risk management: Avoid these common errors in self-defense!" by Claudia Dobbs, MA (April)

Access to prenatal records should be instantaneous

Minimal compliance with an antiquated American College of Obstetricians and Gynecologists (ACOG) guideline to send prenatal records at least once to the hospital by 36 weeks' gestation is NOT "an excellent practice," as suggested by Claudia Dobbs. Such a practice often means that our highest-risk patients—those 12% of births that are preterm—will likely be managed without any prenatal records, especially on nights and weekends. For the rest of our patients, this obsolete tradition leads to the commonplace scenario in which patients are managed with incomplete, outdated records—or none at all.

Risk managers and policy makers should insist that complete and up-to-date prenatal records be made available within

seconds to clinicians in labor and delivery, 24 hours a day, 7 days a week, and at any gestational age.

Ms. Dobbs' "helpful hint" and ACOG's current guideline should no longer be condoned or even tolerated in 2007, when effective digital solutions exist that eliminate uninformed labor-and-delivery care forever.

Donald W. Miller Jr, MD
Shawnee, Kan

Ms. Dobbs responds:

Only a few OBs can send records "within seconds"

I applaud Dr. Miller for promoting ideal communication between treating physicians to ensure safe patient care. His comments certainly demonstrate why physicians should seriously consider interoperable electronic medical records (EMRs). Unfortunately, his recommendations are feasible for only a small minority of physicians. Many of the obstetricians surveyed by my organization's Loss Prevention Department report that they forward their prenatal records within the last trimester, as near to the estimated delivery date as possible. Very few doctors have EMRs and digitalized prenatal forms, and fewer still are interoperable with the local hospital's EMR system, so their ability to send information digitally is limited. They certainly cannot forward their records "24 hours a day, 7 days a week" or make them available "within seconds," especially on weekends or after hours.

To promote patient safety and decrease physician liability, I maintain that, if a treating obstetrician periodically forwards up-to-date copies of the patient's prenatal records to the labor-and-delivery unit, the delivering obstetrician will have information available at the time of delivery. If the treating obstetrician discusses high-risk patients with his or her on-call colleagues and documents the discussions, the delivering physician will be informed and the treating obstetrican's risk will therefore be reduced.

Preterm delivery is certainly a difficult matter. I really hope that the patient's treating obstetrician is handling these cases personally and not relying on an on-call OB (nights, weekends) to do so without counsel.

CONTINUED

"Adnexal masses in pregnancy," by Mitchel S. Hoffman, MD, and Robyn A. Sayer, MD (March)

Some anesthesiologists prefer regional anesthesia in pregnancy

I appreciate the information offered by Dr. Hoffman and Dr. Sayer regarding the management of adnexal masses in pregnancy. I have encountered resistance to laparoscopy in pregnant patients from anesthesiologists, who would often prefer laparotomy under regional anesthesia to the general anesthesia required for laparoscopy.

Have the authors encountered this problem?

Eric Rothschild, MD
Fort Lauderdale, Fla

Dr. Hoffman and Dr. Sayer respond:

Large series support safety of general anesthesia

We have encountered the same concern from some anesthesiologists at our institution regarding the use of general anesthesia for elective surgery during the first trimester of pregnancy.

The teratogenicity noted in animal studies and anecdotal reports has not been observed in large case series. Most of our anesthesiologists administer general anesthesia in this setting, but avoid certain agents (eg, nitrous oxide).

Please take a moment to share your opinion!

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