COMMENT & CONTROVERSY

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"Reducing the medicolegal risk of vacuum extraction," by Martin L. Gimovsky, MD, and Ji-Soo Han, MD (June)

Was vacuum extraction an appropriate option?

Drs. Gimovsky and Han describe a case in which a patient who was pregnant with her first child underwent labor augmentation at term to achieve complete dilation. She then progressed over 3 hours from +1 to +2 station. At that point, she was offered the following options: (1) continue to push, (2) vacuum extraction, or (3) cesarean section on the basis of "protracted descent." She opted for cesarean delivery, and the fetus was successfully delivered from occiput-posterior position.

Is it within the standard of care to offer the option of additional pushing to a patient with a fetus in occiput-posterior position who has already pushed for 3 hours to advance 1 station? If so, how does one evaluate progress and account for the expected caput and molding? Was this a mid-pelvic delivery? *Dennen's Forceps Deliveries*[1] states that operative vaginal delivery from occiput-posterior position may be at a higher station than anticipated, and *Obstetrics Forceps*[2] describes delivery of a crowning fetus in occiput-posterior position in a primiparous patient as "mid-pelvic."

Was the patient Drs. Gimovsky and Han describe a "marginal" or "poor" candidate for vacuum extraction? According to Table 2 in their article, she would have been a marginal candidate based on her primiparous status and the occiput-posterior position of the fetus, but she would have been a "poor" candidate based on her protraction disorder in the second stage.

Drs. Gimovsky and Han state that "all risks" must be discussed with the patient. Did they discuss the 1% to 3.8% risk of subgaleal hemorrhage and its associated 2.7% to 22.8% risk of death? Is it within the standard of care to offer such a patient vacuum extraction?

Russ Jelsema, MD
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References

1. Hale RW, Dennen EH. Dennen's Forceps Deliveries. 4th ed. Washington, DC: American College of Obstetricians and Gynecologists; 2001:114.
2. Laufe LE. Obstetric Forceps. New York: Harper & Row, Hoeber Medical Division; 1968.

"Time limits should serve to remind both patient and practitioner that alternatives to expedite delivery may be warranted"

Dr. Gimovsky responds:

Fetal position was unknown until time of C-section

We appreciate Dr. Jelsema's thoughtful comments. The appropriate duration of the second stage of labor is controversial and has generated diverse opinions.[1,2] Time limits should serve to remind both patient and practitioner that the process has been prolonged, and that alternatives to expedite delivery may be warranted.[3]

In the case Dr. Han and I presented within our article, the occiput-posterior position was detected at the time of cesarean section and so did not affect the patient's management leading up to that point. We did not recommend vacuum extraction, but only suggested it as an option. Given the clinical diagnosis of

protracted descent, the patient's primigravid status, and the unrecognized position of the fetal head, we agree that this patient was a marginal choice at best for operative vaginal delivery. Either continued pushing or cesarean section was a more appropriate choice.

However, practitioners should also recognize the wide range of patient preferences regarding mode of delivery. The apportionment of risk for a woman undergoing childbirth is a personal choice that should be made in conjunction with her physician's recommendations.

References

1. Hellman LM, Prystowsky H. The duration of the second stage of labor. Am J Obstet Gynecol. 1952;63:1223–1233.
2. Menticoglou SM, Manning F, Harman C, Morrison I. Perinatal outcomes in relation to second stage duration. Am J Obstet Gynecol. 1995;173:906–912.
3. O'Grady JP, McIlhargies CJ. Instrumental delivery. In: O'Grady JP, Gimovsky ML, McIlhargie CJ, eds. Operative Obstetrics. Baltimore: Williams & Wilkins; 1995:177–208.

"Limited implementation of EMR can provide immediate and obvious clinical value with little change to workflows"

"Is it time for electronic medical records in your practice?" by G. William Bates, MD, MBA (July), and "Do electronic medical records make for a better practice?" a roundtable discussion moderated by G. William Bates, MD, MBA (August)

You can make a partial transition to e-records

Dr. Bates presented an educational and seasoned overview of electronic medical records (EMR)—words of wisdom that should certainly be read by all clinicians contemplating use of EMR. However, Dr. Bates and the panelists for his roundtable discussion took an all-or-none approach to EMR implementation, suggesting that a practice has only two choices:

- Implement a comprehensive, paperless EMR and patient-management system that may cost many tens or hundreds of thousands of dollars and can potentially disrupt every aspect of a practice or organization
- Stick with paper records and forfeit all of the economic and clinical value of EMR.

I would like to propose a third option: graduated implementation of EMR in a single area of ObGyn practice—an area where access to clinical records matters most—making EMR more palatable to technology-wary, litigation-averse, and financially strapped clinicians. Obstetrics lends itself perfectly to an exchange of paper prenatal records for always-accessible electronic prenatal records.

Such limited implementation, at a fraction of the cost of comprehensive EMR, can provide immediate and obvious clinical value with little change to workflows set up with paper prenatal records in mind. This pragmatic stepwise approach to digital care may be especially useful in practices populated by one or more clinicians who are resistant to overwhelming leaps but can tolerate sensible smaller steps.

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Dr. Bates responds:

Incremental adoption is not yet practical

Five years ago, I would have agreed with Dr. Miller about incremental adoption of EMR. In fact, I, too, advocated such an approach. However, I quickly learned that physicians want a system that will provide electronic management of most—if not all—aspects of their practice. Otherwise, they will "wait and see" rather than adopt EMR. I think the evolution of EMR feature development has delayed adoption of EMR.

The problem with incremental adoption of EMR is the variation in documentation that it creates in a practice using a conventional paper-based system. Physicians and their staff have to remember

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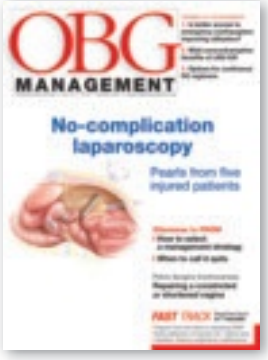
to perform certain functions in the EMR and others on paper. This bifurcation of systems creates dysfunction in process and progress. Moreover, any system that enables incremental adoption must have the functionality to become a comprehensive EMR or be integrated into a comprehensive EMR. Universal interoperability of systems is a goal of EMR users and vendors, but remains just that—a goal. When that goal is realized, incremental adoption of disparate systems may become reality.

"Don't screen for ovarian Ca—but *do* pursue early detection," by Robert L. Barbieri, MD (Editorial, August)

Ovarian cancer screening can target high-risk women

As Dr. Barbieri points out, the combined use of ultrasonography and CA-125 as a screening test is not cost-effective and would lead to many unnecessary interventions. But this observation is true only if you perform the test on every patient regardless of risk. Serial CA-125 levels using the established Risk of Ovarian Cancer Algorithm (ROCA) improves specificity to 99.7% and positive predictive value to 13%, according to the ROCA Screening Study Group, in a study presented at this year's meeting of the American Society of Clinical Oncology. That study defined "high-risk" as:



- BRCA1 or BRCA2 mutation in a patient or her first- or second-degree relative
- two or more cases of ovarian cancer or early-onset breast cancer in a patient or her first- or second-degree relatives, or both
- Ashkenazi ethnicity and one or more cases of breast or ovarian cancer in the individual or her first- or second-degree relative, or both.

Of course, women who have a history of ovarian cancer were not included in the study, which involved 2,343 high-risk women and 19,549 CA-125 tests, totaling 6,284 woman-years of screening.

Perhaps we should target these categories of patients for screening in addition to the other pointers outlined in the editorial.

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Reference

1. Skates SJ, Drescher CW, Isaacs C, et al, for the ROCA Screening Study Group. A prospective multicenter ovarian cancer screening study in women at increased risk. Abstract 5510. J Clin Oncol. 2007 ASCO Annual Meeting Proceedings Part 1;25(18S):5510.

Dr. Barbieri responds:

High-risk women deserve a specialized care plan

I thank Dr. Boulos for her important comments alerting our readers to the clinical characteristics of women who are at very high risk of ovarian cancer. These women deserve a specialized care plan that may include regular pelvic ultrasonography and serum CA-125 measurements. In addition, a discussion of the risks and benefits of bilateral salpingo-oophorectomy may be appropriate. As Dr. Boulos suggests, clinicians may need to develop specialized processes for reliably identifying in their clinical practices the groups of women included in the study by Skates and colleagues.

"Serial CA-125 levels using the Risk of Ovarian Cancer Algorithm improves specificity to 99.7%"

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