"CAN INTRAUTERINE GROWTH RESTRICTION BE PRESENT IN THE FIRST TRIMESTER?"
BY JOHN M. THORP JR, MD
(EXAMINING THE EVIDENCE, JUNE)

We need to pay closer attention to the 1st trimester

Intrauterine growth restriction (IUGR) can be present in the first trimester, but we don't talk about it because of a lack of documentation and our vague conception of IUGR. Some definitions need to be revised and updated, I believe, to reflect current knowledge and practice.

For instance: Loss of a fetus weighing less than 500 g is not always an abortion; it could represent severe IUGR in a fetus well past the 20-week mark. I have seen severe growth restriction in the first trimester on at least two occasions. Both cases were caused by cord problems—in one case, severe stricture; in the other, a tightened knot.

Close attention to first-trimester growth and development is possible now that technology has been developed, but does anyone (except the patient) care about the first trimester? ObGyn generalists consider a loss during the first trimester an abortion, and a maternal–fetal medicine (MFM) specialist will not even see a patient until she passes 20 weeks. In my opinion, the first 20 weeks are a dangerous time and should receive close attention from the MFM specialist to ensure survival of the fetus.

Stefan Semchyshyn, MD
Jonesborough, Tenn

›› Dr. Thorp responds:

Clearly, we have much to learn

I appreciate Dr. Semchyshyn's thoughtful comments. Caring and being able to change the outcome of a first-trimester problem are separate issues; an inability to alter pathophysiology in early pregnancy should not be confused with a lack of empathy. Ignorance clearly abounds about the biology of human pregnancy in the first trimester and, as Dr. Semchyshyn points out, we have much to learn.

JUNE 2008

"HOW WILL WE KNOW IT WHEN WE'VE GOT THE RIGHT CESAREAN RATE?"
BY ROBERT L. BARBIERI, MD
(JUNE EDITORIAL)

Soon, we will have only two options for delivery

Dr. Barbieri touches on a topic that is as fascinating as it is frustrating. On one hand, we keep asking ourselves what is the optimal cesarean delivery rate and aim, insatiably, to make it as low as we can safely achieve. On the other hand, we have neglected to offer residents basic obstetric tools. I have seen young colleagues unable even to rotate a presentation from occipital-posterior to occipital-anterior to ease the delivery.

We have abandoned almost completely the teaching of instrumental deliveries (except, perhaps, for outlet vacuum extraction) and breech deliveries, leaving young obstetricians with only two options, as some of my residents used to put it:

CONTINUED ON PAGE 19

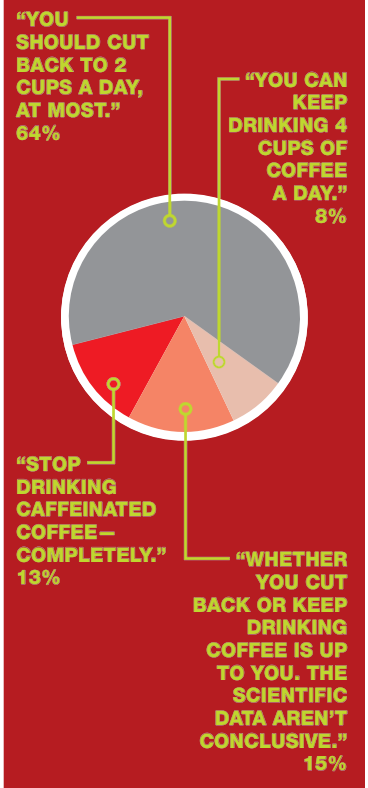
Instant Poll Results

MARCH 2008

Coffee and conception—what's your counsel?

A woman drinks 4 cups of caffeinated coffee daily but reports no other source of caffeine, which means that she consumes about 500 mg of caffeine a day. She tells you that she's concerned about the impact of caffeine on a future pregnancy.

What would you say to this patient about her consumption of caffeine when she begins to try to conceive and, later, while she is pregnant?



Instant Poll → page 14

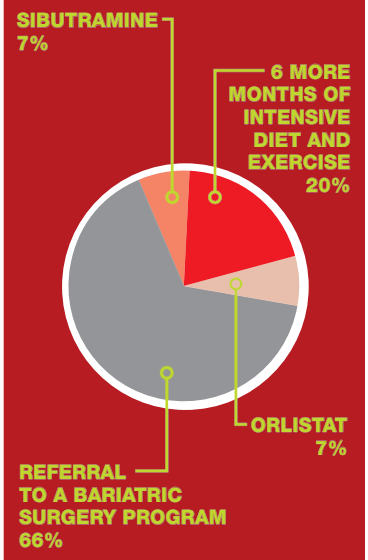
Instant Poll Results

APRIL 2008

Failed weight loss: Take the next step

Your patient is a 27-year-old woman who has a body mass index of 41 and polycystic ovary syndrome. Her medications are an estrogen–progestin oral contraceptive and metformin, 1,500 mg/day.

She has tried to lose weight many times, without lasting success. She has consulted with nutritionists, personal trainers, and endocrinologists. The next step is yours:



Instant Poll → page 14

Comment & Controversy

an easy cesarean section or an easy vaginal delivery.

Add to this the rising demand for elective cesarean delivery and I have no doubt that, in the next few years, our C-section rate will be closer to 50%, if not higher. Ironically, it will be the "right" rate because new obstetricians will lack the ability to deal with difficult deliveries.

Tomas A. Hernandez, MD
Pasco, Wash

Midwife-attended births have lower C-section rate

In our practice for 30 years, about 85% of our private-pay patients have been cared for by midwives, and our primary cesarean rate has remained unchanged at 9%; this includes women who have gestational diabetes. Our total rate is 17%, with exemplary outcomes for both mothers and babes.

Lynn Schimmel, MS, NP
Sutter West Medical Group
Women's Health
Davis, Calif

›› Dr. Barbieri responds:

5 ways to reduce the C-section rate

I appreciate Dr. Hernandez's and Ms. Schimmel's comments and agree that there are approaches that would likely lower the cesarean delivery rate in the United States. As mentioned in my editorial, five interventions that might lower the cesarean delivery rate are:

- *when counseling pregnant women, highlight the risks of cesarean delivery and encourage vaginal birth*
- *reduce the rate of elective induction in uncomplicated pregnancy*
- *encourage a trial of labor after cesarean delivery*
- *reduce the rate of elective primary cesarean delivery*
- *prioritize the teaching of operative delivery during residency.*

A major point of my editorial is that, in the United States, the C-section rate is at an historic high, but still comparable to that in many European countries that rely heavily on midwifery care. The US rate is below the rate in China, Mexico, Brazil, Italy, and, surprisingly, Cuba.

MEDICAL VERDICTS
(MAY)

It's unclear what, exactly, juries base their decisions on

Every month I am amazed, shocked, and distressed—and, occasionally, reassured—by the cases presented in your Medical Verdicts column. The May installment was no exception. Missed meningitis? According to the case description, the high-risk ObGyn failed to detect streptococcal meningitis in a 46-year-old woman pregnant with twins, and both the woman and the twins died—but the defense verdict suggests there are more details than were reported.

Contrast that with the case of trocar injury to the right common iliac artery during diagnostic laparoscopy. From the details presented, it sounds as if this was a known complication of surgery that was appropriately handled. The $312,645 verdict would seem to indicate that this was not the case—or, at least, that that is what the plaintiff's attorney convinced a judge or jury to believe.

There appears to be no consistency in jury verdicts, and that is what makes us fearful to practice in this environment.

Patricia S. Thayer, MD
Houston, Texas

Editors' note: The two cases to which Dr. Thayer refers are, respectively: Escambia County (FL) Circuit Court, Case No. 05-CA-527; and Hamilton County (TN) Circuit Court, Case No. 99-217.