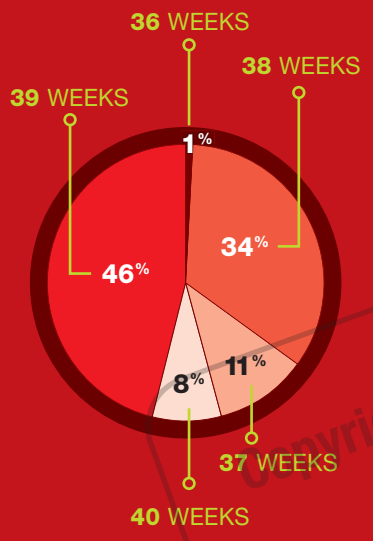
Instant Poll Results

From April 2009

What's the earliest date at which you're willing to schedule elective repeat cesarean delivery?



When a healthy woman has a scheduled elective repeat cesarean delivery, what is your *usual* practice for preventing deep venous thrombosis?

- **45%** I recommend early ambulation postoperatively
- **10%** I order compression stockings
- **35%** I order pneumatic compression boots
- **5%** I prescribe an anticoagulant
- **5%** I don't uniformly order DVT prophylaxis in this setting

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"PREECLAMPSIA AND ECLAMPSIA: 7 MANAGEMENT CHALLENGES (AND ZERO SHORTCUTS)"
JOHN T. REPKE, MD, AND BAHA M. SIBAI, MD (APRIL 2009)

If you think it's preeclampsia, get aggressive

I enjoyed the informative article on preeclampsia by Dr. John T. Repke and Dr. Baha M. Sibai. I would summarize it by saying: Always think preeclampsia in a patient who even looks "toxic," and always be aggressive.

A blood pressure level of 140/90 mm Hg has been my cutoff ever since my residency in the 1970s, when Dr. Leon Chesley oversaw all of our toxemic patients—and we had them each and every day of our training at Kings County Hospital in Brooklyn, New York. Over my 35 years in practice, I would estimate that 90% of the severe complications that have occurred during pregnancy in my patients have been related to preeclampsia. Yes, there were patients who had diabetes or cardiac conditions, but the hypertensive gravida has always been the one to be on the lookout for.

Here's my advice if you want to stay out of trouble: Don't be conservative, try to avoid expectant management, get out the old mag sulfate, and plan on getting that patient delivered as quickly as possible.

Barry Kramer, MD
Bay Shore, NY

›› Dr. Repke and Dr. Sibai respond:

We appreciate Dr. Kramer's remarks and largely agree with him. Meticulous attention to examination of the patient, careful regard for gestational age, and vigilance to avoid the complications associated with uncontrolled hypertension and eclampsia will yield the best outcomes. Not all associated complications are preventable, and delivery of the fetus and placenta remains the cure for this disease.

APRIL 2009

"RECOMMENDATIONS FOR PERINATAL CARE HAVE A TROUBLING PEDIGREE"
ROBERT L. BARBIERI, MD (EDITORIAL, APRIL 2009)

"Medicine by protocol" overlooks many nuances

I appreciated Dr. Robert L. Barbieri's thoughtful response to the rigid guidelines promulgated by the National Quality Forum (NQF). The source of much confusion about these guidelines, which advise against elective cesarean delivery prior to 39 weeks' gestation, is the flawed, recent article in the *New England Journal of Medicine* regarding the alleged risks of elective term cesarean delivery.[1] As a faculty obstetrician for a high-risk, indigent, safety-net population, I have more than a passing interest in this topic. I must counsel and schedule these patients for "elective" repeat cesarean delivery on a routine basis.

My concern is not that 39 weeks is an unreasonable generic target; it is that the subject is nuanced. There is likely some modest, transient neonatal risk during the 37th week of gestation that significantly diminishes during the 38th week—but these risks must be balanced against the benefit of