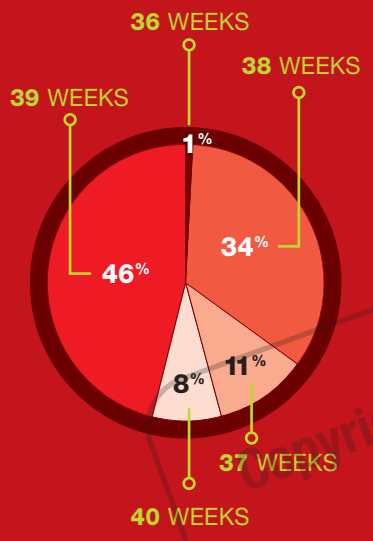
Instant Poll Results

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

scheduled cesarean delivery without labor. As Dr. Barbieri noted, the quality of evidence asserting risk is lacking, a fact that often gets lost in the rush to mandate medicine by protocol.

I offer the following points:

- If a study does not accurately date the pregnancies of its participants by means of early transvaginal ultrasonography (US), it should not make firm pronouncements regarding gestational age and related outcomes. The aforementioned study fails in this regard.[1] Furthermore, accurate US dating, on average, produces an earlier gestational age. As a result, a gestational age of 39 weeks may sometimes represent an otherwise well-dated 38-week gestation.
- The *NEJM* study was further biased by differences between women at 38 weeks' and 39 weeks' gestation on the bases of ethnicity and smoking, both of which are known to affect fetal lung maturation.[1]
- Some studies demonstrate little or no risk during the 38th week.
- The literature suggests that 1) all morbidity at term is transient, without any long-term sequelae, and 2) during the 38th week, any increase in respiratory morbidity is minimal and likely represents transient tachypnea of the newborn—not true respiratory distress syndrome (RDS).
- Amniocentesis carries risk and expense but no proven benefit at term.
- Unscheduled cesarean delivery in general has a significantly poorer outcome than scheduled repeat cesarean delivery for both the newborn and the parturient, and the risk increases the longer the cesarean is delayed. If the patient is in labor, her risk of uterine rupture rises from essentially zero to the quoted figure of 0.7% or higher. Approximately 10% of women scheduled to undergo cesarean delivery during the 39th week will require an unscheduled repeat cesarean earlier.
- There is no physiologic basis for the argument that cesarean delivery at 38 weeks and 5 days is "risky" but magically "safe" 2 days later.
- The risk of stillbirth or fetal demise is very real during the 38th week.

These issues should be taken into consideration by the OB (especially when resources are limited) and should enter into counseling of the patient. Ultimately, the decision should be made by the patient in consultation with her physician, not under threat of "protocol noncompliance" or peer review.

Kenneth W. Elkington, MD
Faculty Obstetrician-Gynecologist
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Greeley, Colo

Reference

1. Tita ATN, Landon MB, Spong CY. Timing of elective repeat cesarean delivery at term and neonatal outcomes. N Engl J Med. 2009;360:111–120.

›› Dr. Barbieri responds:

I deeply appreciate Dr. Elkington's letter. It is far wiser than my original editorial! He concisely and convincingly argues that our key focus should remain on the needs of our patients, not rigid guidelines that are based on evidence from observational studies.

"POSTMENOPAUSAL DYSPAREUNIA—A PROBLEM FOR THE 21ST CENTURY"
ALAN ALTMAN (MARCH 2009)

What to do for postmenopausal dyspareunia

Dr. Alan Altman's article on postmenopausal dyspareunia was informative but short on suggestions.

Estrogen-deficient dyspareunia may be present long before the woman enters menopause. The perineum loses its glistening pink-grayness and turns orangey and dryish.

My suggestions, derived from over three decades of practice, are:

- Tell the patient that TLC (i.e., foreplay) is essential.
- Consider systemic estrogen, i.e., estradiol 1 mg orally or by injection, if it isn't contraindicated.
- Regarding local treatment, remember that lubricants alone do not foster growth of estrogen-dependent epithelium. To make your own local estrogen cream, add estradiol cypionate to the lubricant of your choice.
- Two patients wanted to try sildenafil for low libido, but reported that although the clitoris got warm and the vagina got "juicier," the drug did not enhance their libido. Consider esterified estrogens and methyltestosterone (Estratest) or a small dose (e.g., 0.3 cc) of intramuscular testosterone cypionate. Be sure to use the smallest dose possible.

Not all estrogens are alike. Premarin may be suitable for postmenopausal mares. I prefer to prescribe estradiol because that's what the ovaries produce. It can be used as tablets, cream, patch, or injectable.

Yasuo Ishida, MD
St. Louis, Mo

›› Dr. Altman responds:

When using systemic estradiol, I prefer the nonoral route via patch, gel, ring, or mist, and I tend to avoid both oral and injectable formulations. I would add that oral micronized progesterone does not diminish vaginal blood flow as medroxyprogesterone acetate has been shown to do.

Sildenafil may have a beneficial effect on patients who have arousal disorders, as shown in the literature describing use of testosterone "gates," but is unlikely to have any direct effect on low libido.

In my teaching, I recommend using estrogen first for low libido, prior to any testosterone. Once vaginal dryness and dyspareunia are corrected, the libido often resurfaces, thanks to freedom from discomfort and pain and the return of pleasure.