"MOTHER-, BABY-, AND FAMILY-CENTERED CESAREAN DELIVERY: IT IS POSSIBLE"
WILLIAM CAMANN, MD, AND ROBERT L. BARBIERI, MD
(EDITORIAL; MARCH 2013)

Skin-to-skin cesarean delivery means a lot to patients

I am a childbirth educator at Wentworth-Douglass Hospital in Dover, New Hampshire. I am also one of the childbirth education coordinators at the hospital. We have had a protocol for skin-to-skin cesarean delivery for about a year. This is an issue that I feel very strongly about. I have had emails from past patients saying how much having their babies "skin to skin" after cesarean delivery has meant to them. The research showing benefits of skin-to-skin contact after delivery is strong.

I also teach for Isis Parenting and have been encouraging my students to ask for skin to skin in the OR as well. I'm so encouraged to see Dr. Camann and Dr. Barbieri exploring the possibility of making skin to skin possible in the OR for families in the Boston area.

Another video showing the benefits of skin to skin focuses on breastfeeding. It's called "Breast is Best" and can be viewed at http://www.youtube.com/watch?v=Cuu8UEXzVQ0.

Stacy Swain
Dover, New Hampshire

Family-centered cesareans draw families from afar

We have been offering family-centered cesareans for 1 year now. We call it the gentle cesarean. The baby is taken from the obstetrician and placed skin to skin with the mother. We have noticed that, when left skin to skin, these babies often self-attach and begin to breastfeed as the surgery is completed. Mother, father, and baby leave the OR and go

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to the obstetric postanesthesia care unit. We have had no complications, only happy patients and families. We have also noticed that people are driving past many other hospitals just to have their cesarean with us because we offer this practice.

Nancy J. Travis, RN, BC, CPN, BSN, MS
Cape Coral, Florida

›› Dr. Barbieri responds

Cooperation between team members leads to the best outcomes

We appreciate the video link provided by Ms. Swain and the report from Ms. Travis on the success of patient-centered cesarean delivery in her hospital. In our birthing unit, we greatly value the clinical care and program leadership provided by our childbirth educators, doulas, obstetric nurses, and nurse midwives, who have long championed patient-, baby- and family-centered care. The clinical leadership of our doulas, obstetric nurses, and nurse midwives is critical to continuously improve the care we provide. If we always work together as a team, we will achieve the best outcomes for our patients and their families.

"THE NATURAL HISTORY OF OBSTETRIC BRACHIAL PLEXUS INJURY"
ROBERT L. BARBIERI, MD
(EDITORIAL; FEBRUARY 2013)

Extra caution is warranted in cases of shoulder dystocia

I enjoyed Dr. Barbieri's editorial about obstetric brachial plexus injury (OBPI). I have an additional suggestion to reduce the incidence of this injury.

When faced with a significant shoulder dystocia, I exercise extra caution when applying the McRoberts maneuver and gentle downward pressure of the fetal head simultaneously, as the rotation of the symphysis pubis (and the fetal shoulder) in a cephalic fashion, in concert with forces that keep the fetal head static, may inadvertently cause further "stretch" to the brachial plexus. If initial attempts to apply gentle downward pressure to the fetal head do not relieve the dystocia, I take a quick break to catch my breath and remove my hands from the area, to allow my assistants to rotate the maternal pelvis via the McRoberts maneuver. I then resume attempts to relieve the shoulder dystocia by delivering the posterior arm or performing rotational maneuvers.

Andrea Shields, MD
Dayton, Ohio

The axillae can tell you whether dystocia is present

At vaginal delivery we strive to avoid fetal asphyxia and brachial plexus injury. After delivery of the fetal head, we refrain from pulling on the head, as this could strain the brachial plexus. Rather, we insert a finger into the vagina to identify the fetal axillae, first anteriorly and then posteriorly. If we cannot touch the anterior fetal axilla, that means it is lodged high behind the maternal pubis.

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At this point, we consider internal rotation of the fetal shoulder or suprapubic pressure. If the posterior axilla is palpable, it can be hooked with a fingertip, and gentle traction applied, to bring the posterior shoulder deeper into the pelvis, and this often dislodges the anterior shoulder. Of course, if a fetal hand is encountered posteriorly, it can be delivered, also permitting descent of the anterior shoulder. If neither anterior nor posterior fetal axilla can be palpated, then the shoulders are both outside the pelvis, and the fetal head should be pushed back into the vagina preparatory to cesarean delivery.

James Moruzzi, MD
Olympia, Washington

Study sheds light on risk factors for OBPI

I appreciate Dr. Barbieri's editorial on OBPI. I would like to direct readers' attention to a definitive article on the epidemiology of the injury by Foad and colleagues.[1] This article found that shoulder dystocia was associated with a risk of obstetric brachial plexus palsy 100 times greater than the risk in deliveries unmarked by dystocia. A macrosomic infant had a risk that was 14 times greater than the risk in deliveries involving infants of normal size. And forceps delivery increased the risk of obstetric brachial plexus palsy nine times, compared with unassisted delivery. Both cesarean delivery and multiple gestations were protective against obstetric brachial plexus palsy. Forty-six percent of all infants with obstetric brachial plexus palsy had one or more risk factors, and 54% had no risk factors.

Wayne A. Lippert, MD
Cincinnati, Ohio

Reference

1. Foad SL, Mehlman CT, Ying J. The epidemiology of neonatal brachial plexus palsy in the United States. J Bone Joint Surg Am. 2008;90(6):1258–1264.

›› Dr. Barbieri responds

Call for extra care is warranted

I appreciate Dr. Shields' elegant description of the importance, during shoulder dystocia maneuvers, of taking great care to avoid inadvertently stretching the brachial plexus through the combined forces of suprapubic pressure and gentle downward guidance. She describes the challenge much better than I.

With the growing epidemic of obesity, the effectiveness of suprapubic pressure is likely decreasing. In the obese patient, the mass of tissue around the lower abdomen and pubic area probably reduces the effective transmission of force applied suprapubically to the fetal shoulders.

I appreciate Dr. Moruzzi's advice to identify the position of the posterior and anterior axillae early to help guide the choice of intervention. He also describes the technique of hooking the posterior axilla to bring the posterior shoulder deeper into the pelvis. A similar technique was described by Menticoglou.[1] I recently used this technique, and it worked very well.

I thank Dr. Lippert for the excellent reference on the epidemiology of OBPI. This study analyzed factors associated with injury in over 17,000 newborns with OBPI. The rate of OBPI has been relatively stable over many years despite great efforts to improve our clinical response to shoulder dystocia. As reported by Dr. Shields in her letter, one contributing factor may be how we perform the initial shoulder dystocia maneuvers (McRoberts maneuver and suprapubic pressure), which may exert unintended forces, further compounding the stress on the brachial plexus.

Reference

1. Menticoglou SM. A modified technique to deliver the posterior arm in severe shoulder dystocia. Obstet Gynecol. 2006;108(3 Pt 2):755–757.

"25 YEARS IN SERVICE TO YOU, OUR READERS"
ROBERT L. BARBIERI, MD
(EDITORIAL; JANUARY 2013)

Pleased to receive my own copy of OBG Management

Thanks to Dr. Barbieri and the OBG Management team for including me and other nurse practitioners and physician assistants in the mailing list. I have enjoyed reading your magazine for more than 20 years, having encouraged my collaborating physicians to share theirs. Now I can read my own. I am very grateful. The journal is wonderfully professional and evidence-based.

Colleen R. Nuxoll, WHNP, BC
Effingham, Illinois

›› Dr. Barbieri responds

A welcome to our colleagues

At OBG Management we are thrilled that our nurse practitioner and physician assistant colleagues will be receiving their own copy of the magazine. We welcome you and your colleagues to a vibrant community of clinicians dedicated to advancing women's health.

›› WE WANT TO HEAR FROM YOU!

Drop us a line and let us know what you think about current articles, which topics you'd like to see covered in future issues, and what challenges you face in daily practice.

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