DROSPIRENONE VS NORETHINDRONE PROGESTIN-ONLY PILLS. IS THERE A CLEAR WINNER?
ROBERT L. BARBIERI, MD (FEBRUARY 2022)

Contraception queries

Dr. Barbieri, addressing your editorial on drospirenone and norethindrone pills, can you tell me why there are 4 placebo pills in Slynd? In addition, why did Exeltis choose a 24/4 regimen instead of a continuous regimen? And are there data on bleeding patterns with continuous drospirenone versus 24/4?

Meredith S. Cassidy, MD
Colorado Springs, Colorado

Dr. Barbieri responds

I thank Dr. Cassidy for the excellent question! The purpose of the 4 placebo pills in the Slynd (drospirenone 4 mg) 24/4 progestin-only contraceptive is to induce scheduled bleeding and reduce the number of days of unscheduled uterine bleeding. In a study of 858 patients, compared with a continuous progestin-only desogestrel contraceptive, Slynd with 4 placebo pills, was associated with significantly fewer days of unscheduled bleeding, 22 days versus 35 days (P<.0003) over 8 months of contraceptive use.[1]

The norethindrone progestin-only pill (POP) , which is available in the United States has very weak anti-ovulatory properties. If there were 4 placebo pills in the norethindrone POP, ovulation rates would increase, leading to reduced contraceptive efficacy. In contrast, Slynd with 4 placebo pills has excellent anti-ovulatory efficacy.

Reference

1. Palacios S, Colli E, Regidor PA. Bleeding profile of women using a drospirenone-ony 4 mg over nine cycles in comparison with desogestrel 0.075 mg. *PLoS ONE*. 2020;15:e0231856.

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SHOULD EVERY SCHEDULED CESAREAN BIRTH USE AN ENHANCED RECOVERY AFTER SURGERY (ERAS) PATHWAY?
ROBERT L. BARBIERI, MD (NOVEMBER 2022)

ERAS for all cesarean deliveries

In Dr. Barbieri's editorial "Should every scheduled cesarean birth use an Enhanced Recovery After Surgery (ERAS) pathway?", he and Dr. Schantz-Dunn outline several reasons why the answer is a resounding, "Yes!"

I would suggest that ERAS principles should be used for all cesarean deliveries (CDs), not only scheduled ones. Many components of CD ERAS pathways are equally applicable to scheduled and unscheduled CDs, specifically those components that apply to intraoperative care (antibiotic prophylaxis, skin preparation, surgical technique, uterotonic administration, normothermia, and multimodal anesthesia) and postoperative care (VTE prophylaxis, gum chewing, early oral intake, early ambulation, early removal of bladder catheter, predischarge patient education, scheduled analgesic prophylaxis with acetaminophen, and NSAIDS). Although scheduled CDs have the additional advantage of the pre-hospital components (breastfeeding education, shortened fasting interval, carbohydrate loading, anemia prevention, and physiologic optimization), most of the benefit of ERAS for CD is likely attributable to the intraoperative and postoperative components.

For example, in our CD ERAS program, the median postoperative opioid consumption was reduced from a baseline of more than 100 morphine mg equivalents (MME) in both scheduled CDs (23 MME, interquartile range [IQR], 0-70) and unscheduled CDs (23 MME, IQR, 0-75).[1] Remarkably, 29% of patients in the ERAS pathway used no postoperative opioids at all, a testament to the efficacy of neuraxial morphine and postoperative acetaminophen and NSAIDS. In another program, ERAS was associated with decreased postpartum length of stay and reduced direct costs in both scheduled and unscheduled CDs.[2]

References

1. Combs CA, Robinson T, Mekis C, et al. Enhanced recovery after cesarean: impact on postoperative opioid use and length of stay. *Am J Obstet Gynecol.* 2021;224:237-239.
2. Fay EE, Hitti JE, Delgado CM, et al. An enhanced recovery after surgery pathway for cesarean delivery decreases hospital stay and cost. *Am J Obstet Gynecol.* 2019;221:349.e1-e9.

C. Andrew Combs, MD, PhD
Sunrise, Florida

Dr. Barbieri responds

I am grateful to Dr. Combs' advocacy for applying ERAS principles to all CD births, including scheduled and unscheduled operations. Dr. Combs notes that the intraoperative and postoperative components of ERAS can be used for both scheduled and

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unscheduled CD births. Of particular note is the marked reduction in opioid medication use achieved among Dr. Combs' patients who were on an ERAS pathway. Hopefully, due to Dr. Combs clinical and research leadership many more patients will benefit from the use of an ERAS pathway.

OBGYNS UNITED IN A DIVIDED POST-*DOBBS* AMERICA

ERIN TRACY BRADLEY, MD, MPH, AND MEGAN L. EVANS, MD, MPH (DECEMBER 2022)

ObGyns are not united on this issue

I just finished reading the article by Drs. Bradley and Evans in the December edition of OBG MANAGEMENT. I am an older ObGyn, and I remember when the American College of Obstetricians and Gynecologists and other organizations within our specialty were more circumspect when discussing abortion. They recognized that there were many practitioners who held sincere opinions regarding abortion, feeling that it was ending a sacred life. I am one of those practitioners. I have always felt that we, of all practitioners, should be aware of the reality of early fetal life. We scan patients every day. To see the unborn fetus in all its glory should indelibly impress on each of us that this is life.

The unborn seem not to have advocates like Drs. Bradley and Evans. In fact, those who hold pro-life opinions are regularly silenced in publications and on social media. The Facebooks and Twitters of the world tend to hold us in derision when they are not silencing us. There used to be a detente in our field where we each respected the viewpoint of the other, but now it is nonstop advocacy for abortion. Some authors want to accelerate and intensify that advocacy. I suspect that the pro-life views like mine will continue to be silenced. I just want the authors to know that we are not united in this post-*Dobbs* world. Many of us want appropriate limits on termination. We are not in favor of the unlimited right to abort a fetus up to the moment of delivery.

Steven G. Nelson
Phoenix, Arizona