Letters to the Editor

The Journal welcomes Letters to the Editor; if found suitable, they will be published as space allows. Letters should be typed double-spaced, should not exceed 400 words, and are subject to abridgment and other editorial changes in accordance with journal style.

Outcomes of Birthing Rooms

To the Editor:

The paper by Petravage[1] is an important contribution to the literature on alternative birth. Our recently completed study[2] and survey[3] demonstrates that birthing rooms fall into two broad categories: those that allow all procedures except cesarean section (generally community hospitals with low transfer rates) and those that permit no major procedures (generally tertiary centers with high transfer rates). Presenting transfer rate by parity would help the reader understand the functioning of the birthing room, as would data on women excluded prior to birthing room use.

The use of mean Apgar score can be misleading. Since Apgar scores are always skewed toward the high end of the scale, important information on poor outcomes is easily buried. It is useful to have Apgar scores presented as above or below certain clinically significant levels, and this is generally reported as ≤ 6 or 7. The 5-minute Apgar score, coupled with data on admissions specifically because of asphyxia, is more to the point.

The author draws attention to the development of unforeseen complications that make proximity to a traditional obstetrical unit necessary. This interpretation is dependent on the rules of operation of the birthing room, the quality of staff providing intrapartum care, and proximity of care to obstetrical backup. For example, while Table 5 lists fetal bradycardia, late decelerations, cesarean section, and meconium staining among the reasons for transfer, it is not necessarily true that even these indications can be used to justify the statement that birthing rooms should be in proximity to obstetrical suites. We are given no information about the relationship of these complications to interventions that may have been contributory, such as epidural anesthesia, oxytocin stimulation, the lithotomy position, and the absence of ambulation. No data were given on the time required for transfer or the real urgency of the conditions listed, without which it is not possible to judge the appropriateness of the author's observation about optimal location of birthing rooms. It is always possible that what might seem ideal from the point of view of proximity (and even given rare real emergencies like cord prolapse), perinatal gains through proximity to an operating room may be balanced by iatrogenic losses.[4,5]

Lest I seem too critical, let me assure the author that her survey in

fact represents the state of the art. It is likely that much of the information that I have requested will not have been available because of inadequate record-keeping.[3] If we are to improve the quality of the data, it will be necessary to keep separate birthing room logs that will list major and minor procedures—emphasizing that the birthing room is not just another delivery room.

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References

1. Petravage JB: Outcomes of three birthing rooms. J Fam Pract 16:929, 1983
2. Klein M, Papageorgiou AN, Westreich R, et al: A randomized controlled trial of medical/psychological outcomes in a birth room vs conventional labour and delivery. Presented at the meeting of the Society for Pediatric Research, Washington, DC, May 1982
3. Klein M, Westreich R: Birth room transfer and procedure rates—What do they tell about the setting? Birth 10:93, 1983
4. Klein M, Lloyd I, Redman C, et al: A comparison of low-risk pregnant women booked for delivery in two systems of care: Shared-care (consultant) and integrated general practice unit: 1. Obstetrical procedures and neonatal outcome. Br J Obstet Gynaecol 90:118, 1983
5. Klein M, Lloyd I, Redman C, et al: A comparison of low-risk pregnant women booked for delivery in two systems of care: Shared-care (consultant) and integrated general practice unit. 2. Labour and delivery management and neonatal outcome. Br J Obstet Gynaecol 90:123, 1983

Use of Mini-Wright Peak Flow Meter

To the Editor:

Having used the Mini-Wright Peak Flow Meter for several years in England, I would like to reinforce its usefulness as described by Dr. David Katz *(Katz DN: The Mini-Wright peak flow meter for evaluating airway obstruction in a family practice. J Fam Pract 17:51, 1983).*

I have found four other uses for the meter.

1. *Compliance.* One of the advantages of the Mini-Wright Peak Flow Meter is the rapidity of the test. I offer it to every asthmatic patient on each visit. Asthmatics, like patients with other chronic or relapsing conditions, often find difficulty in complying with preventive treatment such as sodium cromoglycate or beclomethasone, particularly teenagers. We have found that encouraging patients to buy their own mini peak flow meter or lending them one gives them a greater sense of control of their own asthma and greater autonomy, which seems to lead to better compliance and fewer relapses.

2. *Chronic obstructive airway disease.* The meter can also be used to assess the reversible aspects of COAD.

3. *Beta-blockers.* Even cardioselective beta-blockers can precipitate asthma in a susceptible person. The history is our most useful screening test before prescribing these drugs, but a quick measurement of the peak expiratory flow rate (PEFR) is an added safeguard.

4. *Smoking and health education.* The PEFR is lowered in most smokers and the Mini-Wright Peak Flow Meter can be used to demonstrate this and thus help in health education. We know that fear is a poor motivator and cancer by the age of 50 years seems a long way off to most young people. A demonstration that they are not fit and healthy now can be a powerful incentive to stop smoking.

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