

ABORTION ATTITUDES

To the Editor:

Recently, the Journal ran an article on the abortion attitudes of family physicians (*Westfall JM, Kallail KJ, Walling AD. Abortion attitudes and practices of family and general practice physicians. J Fam Pract 1991; 33:47-51*). I would like to speak for the identified minority. I oppose abortion under any circumstance. The reason for this "rigid" stance is that I have accepted the idea that human life begins at implantation. All of us must first define when we believe life begins in order to develop an appropriate policy on abortion. As a physician, once I defined when life begins, I expanded my role as a sworn advocate of preserving life (part of the physician's oath). When one accepts this stance, the issue of abortion becomes not just a women's rights issue, but a human rights issue. Although I am a strong proponent of women's rights, I believe that the issue of human life has greater priority. The issue of abortion then becomes equated with murder.

I realize this is a terribly difficult issue for physicians to confront. I ask that each physician define life first, and then make his or her choice. To those who approve of abortion in cases of Down syndrome, rape, or sexual preference, I pose the question, "Would you allow that woman to decide at birth if that same child should be killed because it was retarded, reminded her of the rapist, or was not of the desired sex?" If your answer is, "Of course not," then what about at 38 weeks, 32 weeks, 26 weeks, 22 weeks, 18 weeks, or 12 weeks? When does life begin? We must answer that first.

Howard Weinberg, MD
Virginia Beach, Virginia

COLPOSCOPY

To the Editor:

We would like to acknowledge that we inadvertently omitted the following information from our article, "Development of a Curriculum in Colposcopy" (*J Fam Pract 1991; 32:590-97*). Many of the activities described in this article were conducted while Dr Caruthers was a fellow in the Michigan State University Primary Care Faculty Development Fellowship Program, East Lansing, Michigan. We regret this omission of an important aspect of the activities described in our article.

Barbara S. Caruthers, MD, MS
Kent J. Sheets, PhD
Department of Family Practice
University of Michigan Medical School
Ann Arbor

SHOULDER DYSTOCIA

To the Editor:

I am sure most family physicians and obstetricians welcome any new ideas for dealing with shoulder dystocia (*Meenan AL, Gaskin LM, Hunt P, Ball CA. A new (old) maneuver for the management of shoulder dystocia. J Fam Pract 1991; 32:625-9*), and I plan to add the all-fours position to my list of maneuvers in the future. I was disillusioned, however, by the emphasis placed on the condition of the perineum as a measure of successful outcome of shoulder dystocia. In instances where the survival of an infant is at stake, I believe that a good infant outcome is more than worth a few stitches to the perineum. I will continue to use episiotomy as one of the maneuvers employed for shoulder dystocia.

Melody Schniepp, MD
Peoria, Illinois

The preceding letter was referred to Dr Meenan and colleagues, who respond as follows:

We appreciate Dr Schniepp's comments but would like to point out that we had not intended to use the condition of the perineum as a measure of successful outcome of shoulder dystocia, but rather to show that the all-fours maneuver creates enough extra space in the pelvic outlet that excellent outcomes can frequently be achieved without performing an episiotomy.

I have found that the perineum is very seldom the only, or even the major obstacle, impeding the birth of the shoulders, and that any part of a baby that needs to get through it will simply tear through it if necessary. In the case presented in the article, it was obvious to me when I put my hand into the vagina that the obstruction was up higher, and the fact that the perineum ultimately accommodated my forearm and both fetal shoulders without tearing suggests that it was not the major obstruction.

The risks vs the benefits of episiotomy is a topic beyond the scope of this letter, but if an episiotomy has already been done during the birth of the head, then the question does not arise. If, however, one has not been done and a shoulder dystocia occurs, the birth attendant is faced with the prospect of incising a perineum to which a pair of fat fetal cheeks is tightly applied. A simple noninvasive maneuver that can be accomplished in 30 seconds will usually make that incision unnecessary or, at the very least, easier to perform without injury to the baby or the attendant's fingers.

For those who are still picturing a cumbersome and time-consuming maneuver, let me emphasize once more that an entire shoulder dystocia delivery in the all-fours position can be accomplished in under 2 minutes, even by an inexperienced or unpre-

pared attendant. The largest baby in Ina May Gaskin's series¹ was delivered by a midwife who had never before delivered a baby (11 lb 8 oz, Apgar scores 9/10). More recently, at our institution, an 11 lb 14 oz infant was successfully delivered by an obstetrician who had never even heard of the maneuver. When other maneuvers failed, the nurses repositioned the mother and coached the physician in the use of the all-fours position on the spot.

Anna L. Meenan

*Department of Family and
Community Medicine*

*The University of Illinois College
of Medicine
Rockford*

Reference

1. Gaskin IM. Shoulder dystocia: controversies in management. *Birth Gazette* 1988; 5:14.

DRUG INTERACTION

To the Editor:

Ciprofloxacin is a synthetic quinoline antibiotic that interferes with hepatic metabolism by inhibiting the cytochrome P-450 system.¹ Recent case reports have suggested that ciprofloxacin use decreases warfarin metabolism and results in increased prothrombin times.²⁻⁴ Herein we report a case of a suspected drug interaction between ciprofloxacin and warfarin.

A 60-year-old, obese, white

male smoker with a history of hypertension, hyperlipidemia, chronic obstructive pulmonary disease, and adult-onset diabetes mellitus was placed on warfarin therapy after suffering a series of transient ischemic attacks as a result of basilar artery stenosis. Concurrent medications included captopril, sustained release theophylline, gemfibrozil, and sustained release nifedipine. Over a 10-month period, the patient achieved a stable prothrombin ratio (PTR) of 1.2 to 1.6 on 10 mg to 12.5 mg of warfarin daily. During this period of observation, the patient had normal liver function tests and no history of hepatic disease despite self-reported heavy alcohol use in the past.

During a routine follow-up visit in January 1991, the patient was evaluated and found to have a PTR of 1.3 while taking a stable warfarin dose of 12.5 mg daily. Two weeks after this routine visit, the patient was evaluated and treated by an orthopedic surgeon with ciprofloxacin 750 mg twice daily for a presumed infection in the left knee joint space. After ingesting ciprofloxacin for 7 days, the patient noted an increased bleeding tendency for which he sought further medical evaluation. On laboratory testing, it was noted that the patient's PTR had increased to 2.74 while on a dose of warfarin that had remained unchanged. Vitamin K was administered; the patient's PTR promptly declined to 1.1.

Although other factors that may alter response to warfarin were present in this patient, such as alcohol use, smoking, hypoalbuminemia,

and gemfibrozil use, each factor was present for the entire course of warfarin therapy and therefore was unlikely to be the precipitating cause of the elevation of the PTR.

We conclude that this case is suggestive of a ciprofloxacin-warfarin interaction. Although other investigators have suggested that a lower dose of ciprofloxacin is not associated with a significant increase in the PTR,⁵ based on this example and previously reported cases,²⁻⁴ we believe that further study on the possible interaction of warfarin and ciprofloxacin is warranted.

Karen C. Johnson, MD, MPH

*Departments of Medicine and
Preventive Medicine*

Ronald H. Joe, PharmD

Timothy H. Self, PharmD

Department of Clinical Pharmacy

University of Tennessee

Memphis

References

1. Polk RE. Drug-drug interactions with ciprofloxacin and other fluoroquinolones. *Am J Med* 1989; 87(5A):76S-81S.
2. Mott FE, Murphy S, Hunt V. Ciprofloxacin and warfarin [Letter] *Ann Intern Med* 1989; 111:542-3.
3. Kamada AK. Possible interaction between ciprofloxacin and warfarin. *DICP Ann Pharmacother* 1990; 24:27-8.
4. Jolson HM, Tanner LA, Green L, Grasele TH. Adverse reaction reporting of interaction between warfarin and fluoroquinolones. *Arch Intern Med* 1991; 151:1003-4.
5. Rindone JP, Keuey CL, Jones WN, Garwal HS. Hypoprothrombinemic effect of warfarin not influenced by ciprofloxacin. *Clin Pharm* 1991; 10:136-8.