

# COMMENT & CONTROVERSY

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“Shoulder dystocia: What is the legal standard of care?”  
by Henry M. Lerner, MD (August)

## Is “expert opinion” good enough for the patient?

I have 3 questions for Dr. Lerner. First, he cited a recommendation from the American College of Obstetricians and Gynecologists (ACOG) on the estimated fetal weight at which to offer cesarean delivery. That recommendation was graded by ACOG as level C: consensus or expert opinion. Should we inform our patients that our recommendation regarding cesarean delivery for certain estimated fetal weights is based on opinion only, or even on level B evidence, defined as “limited or inconsistent scientific evidence”? According to a recent overview of practice bulletins,<sup>1</sup> 60% of the recommendations in the ACOG shoulder dystocia bulletin were level C, 40% were level B, and none were level A.

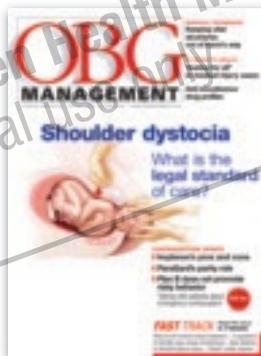
Second, Dr. Lerner stated: “Routine or ‘moderate’ traction is used in most deliveries. The birth attendant almost always depresses the fetal head and applies a moderate amount of traction.” He also observed: “The only time traction is unnecessary is when the expulsive forces of the mother are so strong or uncontrolled that she pushes the baby out entirely on her own.”

The word “most” implies a majority. In my experience—and, I trust, the experience of generations of women delivering babies without obstetrical attendants—the vast majority of babies do not need any type of traction. I teach medical students

and residents that their role in vaginal delivery is to “assist” the birth, and to be prepared to address problems if they occur. How are babies born without attendants applying traction?

Third, Dr. Lerner noted that a recent case report by Allen and Gurewitsch<sup>2</sup> “settled” the question as to whether brachial plexus injury can follow a “traction-free” delivery. As noted in the reference, the injury described by Allen and Gurewitsch was “temporary.” A subsequent paper by Gurewitsch, Allen, and others<sup>3</sup> demonstrated that the vast majority of permanent injuries are traction-related. Are they implying that temporary injuries equal permanent injuries?

Russel D. Jelsema, MD  
Grand Rapids, Mich



## REFERENCES

1. Chauhan SP, Berghella V, Sanderson M, et al. American College of Obstetricians and Gynecologists practice bulletins: an overview. *Am J Obstet Gynecol.* 2006;194:1564–1575.
2. Allen RH, Gurewitsch ED. Temporary Erb–Duchenne palsy without shoulder dystocia or traction to the fetal head. *Obstet Gynecol.* 2005;105:1210–1212.
3. Gurewitsch ED, Johnson E, Hamzehzadeh S, Allen RH. Risk factors for brachial plexus injury with and without shoulder dystocia. *Am J Obstet Gynecol.* 2006;194:486–493.

## Dr. Lerner responds:

### Don't argue for firm data and then fail to provide it

While I respect Dr. Jelsema's right to comment on my article, I find his remarks inappropriate, inconsistent, and, in one case, plainly wrong.

In his first point, Dr. Jelsema takes ACOG to task because its recommendation is based primarily on level C evidence. He wants to know if patients are advised that

**“In my experience, the vast majority of babies do not need any traction”**

the recommendation is based on consensus and expert opinion. Dr. Jelsema also seems to criticize ACOG recommendations based on level B evidence.

Is Dr. Jelsema really proposing that physicians should never advise patients about any matters unless they have been settled by randomized, double-blinded, controlled studies? If all issues in medicine had been settled by this sort of evidence, that position might make sense. But in the real world that is far from the case—as Dr. Jelsema surely knows.

He next argues about whether birth attendants almost always depress the fetal head and apply traction during delivery. His evidence? It comes solely from his own experience and what he teaches his students and residents. He quotes no studies or reports. This certainly does not comport with the standard of evidence he is advocating in the first point of his letter.

Most seriously, Dr. Jelsema's claim that the paper by Gurewitsch, Allen, and others demonstrates that "the vast majority of permanent injuries are traction-related" is absolutely false. The article does nothing of the kind. In fact, it demonstrates only that brachial plexus injuries that result from deliveries involving shoulder dystocia are different and have different risk factors than those that occur when no shoulder dystocia is recorded. Nothing in the article links traction disorders to permanent brachial plexus injuries.

"Is this induction necessary?" by Judith Chung, MD, and Deborah A. Wing, MD (September)

### How soon can oxytocin follow misoprostol?

In their useful discussion, Dr. Judith Chung and Dr. Deborah A. Wing wrote: "Uterine hyperstimulation and meconium-stained amniotic fluid appear to be more common with misoprostol, although these risks can be minimized by using a dose of 25 µg (1/4

of a 100-µg tablet) at an interval of 3 to 6 hours, with oxytocin given no later than 4 hours after the last dose of misoprostol." They probably intended the phrase to be: "with oxytocin given *no earlier than* 4 hours after the last dose of misoprostol" (emphasis mine). A review of published

reports and MedWatch, the US Food and Drug Administration medical products reporting program, indicates that the vast majority of adverse maternal and fetal outcomes associated with misoprostol therapy resulted from the use of doses exceeding 25 µg, dosing intervals more frequent than 3 to 6 hours, addition of oxytocin

less than 4 hours after the last misoprostol dose, or use of the drug in women with prior cesarean delivery or major uterine surgery.

Jeffrey Greenspoon, MD  
Beverly Hills, Calif

### Drs. Chung and Wing respond:

#### Dosing interval was incorrect

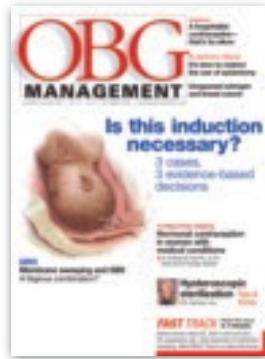
We appreciate Dr. Greenspoon's careful perusal of our article. He is correct that our intention was to emphasize the recommendation that oxytocin should not be administered at an interval less than 4 hours after the last dose of misoprostol, to minimize the risk of uterine hyperstimulation and meconium-stained fluid. We sincerely apologize for this oversight.

"Everything you need to know about the contraceptive implant" by Philip D. Darney, MD, MSc (September)

### In some eyes, Implanon is an abortifacient

I find Dr. Darney's article misleading when it comes to the "2 mechanisms" of action given for Implanon. Inhibition of ovulation and failure of sperm penetration through cervical mucus are discussed, and readers are assured that the device "lacks abortifacient properties." This assertion contradicts

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**"... should we never advise patients about anything unless it has been settled by randomized controlled trials?"**

both the physician package insert and the patient information published by Organon and available on its Web site at [www.implanon.com](http://www.implanon.com). These resources clearly state that “alterations in the endometrium” are an additional mechanism of action, ie, that Implanon could cause failure of blastocyst implantation.

Although some organizations do not consider the loss of a preimplantation embryo to be an “abortion,” it is erroneous to think that every patient will believe so. Indeed, some may pause at the thought that their chosen method of birth control may be causing the loss of early embryos.

Patients and providers deserve to know these facts, and we should be forthcoming about disclosing them. For an excellent review of this subject, please see Larimore’s article, “Postfertilization effects of oral contraceptives and their relationship to informed consent” (*Arch Fam Med*. 2000;9:126–133).

Kyle Beiter, MD  
Phoenix, Ariz

“It’s time to restrict the use of episiotomy” by Robert L. Barbieri, MD (September)

## Don’t let others decide how you should practice

I appreciate Dr. Barbieri’s thoughtful editorial on episiotomy. However, I am afraid we are being victimized by arbitrary numbers thrown at us by a bunch of desk-bound, nonpracticing physicians and bureaucrats. Is the cesarean section rate too high? Is the episiotomy rate too high? Did

any lawyer or insurance company executive help you reach the crucial decision?

Yes, the vaginal ring structure may dilate to accommodate the baby’s passage, but how about the introitus? It is a rare perineum that opens to 10 cm! I most certainly don’t like to repair an irregularly torn perineum! No one can make the decision for you; you have to be there to determine the best approach, based on how the perineum stretches. (Have your scissors handy, just in case!)

Don’t let the players of numbers, such as Cochrane reviewers, reduce a complicated procedure like childbirth into a simpler model. And don’t let bystanders dictate what you can or cannot do. Remember, we have been trained to do the best for the woman and baby under the circumstances, and no two cases are alike!

Yasuo Ishida, MD  
St. Louis, Mo

Dr. Barbieri responds:

## Episiotomy is bound to attract more scrutiny, not less

I appreciate Dr. Ishida’s assessment of “battlefield conditions” from the front lines of obstetrical care, and I empathize with his perspective. Unfortunately, I think we are entering an era when assessment of physician practice patterns, expressed as rates of performance of certain procedures and rates of “complications,” will become routine. It is likely that the rate of episiotomy will decrease in the United States. The degree to which “outlier” physicians will attract scrutiny from hospital credentialing committees and regulatory agencies is unclear. ■

**“We are being victimized by a bunch of desk-bound, nonpracticing physicians and bureaucrats”**

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