

COMMENT & CONTROVERSY

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“Obstetric anal sphincter injury: 7 critical questions about care,” by Raneer Thakar, MD, MRCOG, and Abdul H. Sultan, MD, FRCOG (February)

Forceps are not the culprit. It's the user

In my opinion, the alleged greater likelihood of anal sphincter tear when forceps are used, compared with the vacuum extractor, does not arise from the instrument itself, but the way it is used—specifically, the injudicious application of traction. Such excess traction is a likely occurrence, particularly in the presence of unrecognized cephalopelvic disproportion, and may be the major risk factor for anal sphincter injury. In fact, because the amount of traction applied can only be measured *subjectively*, the possibility for excess traction always exists, particularly when forceps are used by the less learned.

To eliminate this risk, scientists are developing an electronically controlled forceps that will make it possible to:

- measure *objectively* the traction exerted during delivery
- promptly alert the obstetrician when safety limits are exceeded
- generate a hard copy printout of the “pull” to be included in the patient’s hospital medical record.¹ The printout can be used for research purposes or, in the event of litigation, as direct evidence that no undue traction was applied.

Incidentally, the authors’ recommendation to resort to the vacuum extractor rather than forceps overlooks the fact that these two instruments are not equivalent and, therefore, cannot be

used interchangeably. Forceps are used to actively deliver the baby, i.e., to replace the *vis a tergo*; vacuum extraction is used to augment, not replace, the natural forces of labor.

Nicola Perone, MD
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Reference

1. Advanced Obstetric Systems LLC [personal communication].



“The possibility for excess traction always exists, particularly when forceps are used by the less learned”

Dr. Thakar and Dr. Sultan respond: Use the vacuum extractor until this new device is proven

We appreciate Professor Perone’s interest in our article. The aim of our paper was to provide evidence-based medicine from randomized trials and resort to expert experience only in the absence of such trials.

In principle, electronically controlled forceps appear promising, but until shown to be superior to a vacuum extractor in a randomized controlled trial, the vacuum extractor should be the instrument of choice.

“Fatigue: It’s a fickle member of the obstetrical team,” by Robert L. Barbieri, MD (Editorial, December 2007)

Limitations on work hours make residents and patients safer

I trained in the era of 36-hour call every third to fourth night and 120-hour workweeks in residency. I had four young children, including a toddler. My husband picked up the oldest three kids, but I

would swing by the day-care center for my youngest child on my way home from work.

One evening, I awoke at the wheel as we jolted to a stop in a bar ditch, with my 3-year-old exclaiming, “Whoa, Mommy! Whoa, Mommy!” Neither I nor my daughter was hurt, but we had just come through a busy two-way stop at a major highway intersection, which I did not remember driving through. I apparently crossed through it and entered the ditch several hundred feet past the intersection.

After that, I never picked up any of my children after call again. Changing

the way we worked as residents was not an option—it was accepted that that was the way things were.

I am teaching now, after many years in private practice in which I often carried over to the next day to see patients or operate after being up all night with a delivery. I welcome the changes taking place in residency and practice. Although I do believe there are times when continuity of care is lost in what has become shift work with the residents, I think residents and patients are safer in the long run—even if it is just to drive home after work.

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Erratum

“Obstetric anal sphincter injury: 7 critical questions about care,” by Raneer Thakar, MD, MRCOG, and Abdul H. Sultan, MD, FRCOG (February)

Figure 9 on page 65 of the February issue should have reflected the uncertainty of cesarean section as a management option in symptomatic women with a se-

vere injury and in asymptomatic women with a borderline injury; in some cases, vaginal delivery may be a better option. In addition, the definitions in the legend were incorrect.

The corrected algorithm and legend appear below and in the article archives at www.obgmanagement.com.

“There are times when continuity of care is lost in what has become shift work with the residents, but I think residents and patients are safer in the long run”

FIGURE 9

