LETTERS

B-Lynch suture technique, HMO comments questioned

I am always disappointed when respected clinicians say or do foolish things. First, in "B-Lynch suture: a new approach to intractable postpartum hemorrhage" [September], Giancarlo Mari, MD, et al advocated performing the procedure through a Pfannenstiel incision! Since this technique should only be performed in cases of life-threatening hemorrhage, it should be done through a vertical midline incision. There is simply no clinical justification for wasting time with a Pfannenstiel incision in such cases.

And then, in his vaginal hysterectomy pearls [September], Robert L. Shirley, MD, bemoaned the possibility that health maintenance organizations (HMOs) may eventually "decide that patients should be discharged directly from the recovery room." Too many physicians have forgotten that we alone are responsible for making such decisions, not the HMOs. These organizations don't discharge patients early; frightened doctors do. Such passive acquiescence to potential HMO abuse by a veteran surgeon sets a very bad example for those physicians who still place their patient's safety above all else. Please tell me he was only joking.

Kenneth A. Thomas, MD
Stratford, Conn

DR. MARI AND COLLEAGUES RESPOND:

We appreciate Dr. Thomas' comments but disagree with his admonition that the B-Lynch suture should be reserved for life-threatening hemorrhage and, then, only via a vertical midline incision.

As we pointed out in the article—and as recent data have indicated[1,2]—a unique attribute of the technique is that it is efficacious not only when there is life-threatening hemorrhage but when the uterus is compromised as well.

With the early recognition of hemorrhage and prompt application of the B-Lynch suture, the clinician can treat the bleeding in a timely fashion, thus avoiding the need for an urgent vertical abdominal incision and the attendant increase in complications compared with the Pfannenstiel approach.

REFERENCES

1. B-Lynch, et al. B-Lynch surgical technique for the control of massive postpartum hemorrhage: an alternative to hysterectomy? Five cases reported. *Br J Obstet Gynaecol.* 1997;104:372-375.
2. Ferguson JE II, Bourgeois FJ, Underwood PB. B-Lynch suture for postpartum hemorrhage. *Obstet Gynecol.* 2000;95:1020-1022.

DR. SHIRLEY RESPONDS:

Yes, my comment about the HMOs reducing the length of hospital stay for a vaginal hysterectomy to 1 day was a feeble attempt at humor. With regard to the current state of affairs with HMOs, I feel that we have to laugh or cry, and I'm all out of tears. As the Romans would have said, *Castigat ridendo mores* ("He corrects customs by laughing at them").

Injecting 30 cc of 2% lidocaine challenged

In "Cone biopsy: perfecting the procedure" [January], Marc Toglia, MD, stated that he injects between 20 and 30 cc of 2% lidocaine with epinephrine in a concentration of 1:200,000 paracervically. The maximum recommended dosage of this premixed solution is 500 mg or 25 cc. Using 30 cc, or 600 mg, of lidocaine is potentially lethal.

Stephen Straubing, MD
Fairfield, Ohio

DR. TOGLIA RESPONDS:

I would like to thank Dr. Straubing for pointing out my error in the dose of lidocaine used for a paracervical block. Rather, I should have directed the physician to inject a premixed solution of 1%—not 2%—lidocaine with epinephrine para cervically. I typically use 10 to 20 cc and prefer not to exceed a total of 200 mg.