"AN APPEAL TO THE FDA: REMOVE THE BLACK-BOX WARNING FOR DEPOT MEDROXYPROGESTERONE ACETATE"
ANDREW M. KAUNITZ, MD; DAVID A. GRIMES, MD (EDITORIAL; AUGUST 2011)

Black box warning for DMPA needs to go

I couldn't agree more that the black box warning for depot medroxyprogesterone acetate (DMPA) should be removed by the FDA. Since this warning was instituted, I have continued to use the agent with some increased concern and, of course, enhanced informed consent of my patients. It has definitely led to more bone-density scans, which have all been negative in my experience.

Patients do benefit from this treatment, so it makes no sense to create an artificial obstacle to its use in the absence of scientific data.

Terrence McGaw, MD
Reno, Nev

Black box warning encourages defensive practices

I agree that the black box warning should be removed. I have continued to order DMPA for my patients, but for those who have been using it for years, I have also been ordering bone-density studies periodically from a "defensive" medical standpoint.

Paul D. Manganiello, MD
Lebanon, NH

›› Dr. Kaunitz responds

Routine bone-density assessment is unnecessary

I appreciate the thoughtful letters from Dr. McGaw and Dr. Manganiello, who, like me, continue to find that injectable contraception remains an important option for our patients. One suggestion: Because changes in bone density associated with DMPA are reversible and have not been associated with postmenopausal osteoporosis or fractures, ACOG does not recommend routine bone-density assessment in women using DMPA for birth control.[1]

AUGUST 2011

Reference

1. American College of Obstetricians and Gynecologists Committee on Gynecologic Practice. ACOG Committee Opinion No. 415: Depot medroxyprogesterone acetate and bone effects. Obstet Gynecol. 2008;112(3):727–730.

"HAVE YOU MADE BEST USE OF THE BAKRI BALLOON IN PPH?"
ROBERT L. BARBIERI, MD (EDITORIAL; JULY 2011)

Pearls for postpartum hemorrhage

I'd like to offer the following pearls for managing postpartum hemorrhage:

If the patient has had an epidural, perform a quick suction dilatation and curettage in the bed. Then suture the cervix at the 9 o'clock and 3 o'clock positions, closing the opening to 4 cm to 5 cm before placing the balloon. I recommend inflating the balloon to 300 cc to 500 cc.

If a balloon is not available, pack the uterus with two lap sponges tied together. Transfuse the patient with "O"-negative blood until the blood can be typed and crossed. If the patient is still bleeding, call an interventional radiologist to place gel foam in the uterine arteries. This procedure can take 1 or 2 hours, so make sure the patient is receiving enough blood products during that time.

Do not take the patient to surgery if she is experiencing disseminated intravascular coagulation.

Wendell Courtney, MD
Leesburg, Fla.

›› Dr. Barbieri responds

Pearls are appreciated

On behalf of the readers of OBG MANAGEMENT, I thank Dr. Courtney for the wonderful clinical pearls! I will try to incorporate them in my practice the next time I use a Bakri balloon.

"HIGH UTEROSACRAL VAGINAL VAULT SUSPENSION TO REPAIR ENTEROCELE AND APICAL PROLAPSE"
MICKEY KARRAM, MD; CHRISTINE VACCARO, DO (JUNE 2011)

Are delayed absorbable sutures durable?

I loved the article by Dr. Karram and Dr. Vaccaro. I wonder whether they find delayed absorbable sutures to be as durable as permanent sutures? What does the raw surface of the posterior vaginal cuff "heal to" or granulate to when absorbable sutures are used, to allow it to be a permanent fix? In other words, once the suture dissolves, what prevents the cuff from slipping out?

Thomas Wimbrow, MD
Auckland, New Zealand

›› Dr. Karram and Dr. Vaccaro respond

Scarification can be expected

Although Dr. Wimbrow's question about absorbable sutures makes sense theoretically, scarification does occur

with a delayed absorbable suture such as polyglactin 910 or polydiaxanone, even though there are no raw surfaces. Our 5-year outcome data nicely document this fact.[1] We do bar the patient from heavy lifting, exercise, and other strenuous activity for 6 weeks.

Reference

1. Silva WA, Pauls RN, Segal JL, Rooney CM, Kleeman SD, Karram MM. Uterosacral ligament vault suspension: 5-year outcomes. Obstet Gynecol. 2006;108(2):255–263.

"UPDATE ON INFECTIOUS DISEASE"
ALAN T. N. TITA, MD, PHD; AKILA SUBRAMANIAM, MD; WILLIAM W. ANDREWS, MD, PHD (JUNE 2011)

JUNE 2011

The cesarean-delivery rate will decline only when we are "honest" about the indication

In their article on infectious disease, Dr. Tita and colleagues make mention of the fact that cesarean delivery "accounts for one third (more than 1.3 million) of all births in the United States each year and carries a risk of infection at least five times higher than that associated with vaginal delivery."

Is the rate of cesarean delivery *too damn high*? Of course it is! In my decades-long practice in maternal-fetal medicine, in which I cared exclusively for high-risk patients, my cesarean-delivery rate was always lower than that of any hospital I was affiliated with. As I see it, the rate of cesarean delivery is escalating needlessly—and the rising rate benefits the hospital and physician, but not necessarily the patient. Not only the fear of lawsuits, but also significantly better payment for cesarean than for vaginal delivery, plays a role in these numbers. There is also the time factor. With a normal vaginal delivery, a physician may have to sit and wait (without a long cigar nowadays...) and agonize until after the delivery. With cesarean, the job is quite simple, complications are rare, the doc is done within an hour, and everything seems copacetic—until such time as the lawyers start digging, finding faults, and suing even for frivolous negative incidents.

A recent article sheds light on the causes of the rising cesarean-delivery rate.[1] For example, the indication is often questionable. Among the justifications for these questionable cesarean deliveries are concern for fetal well-being, poor progress in labor, and suspicion of macrosomia or preeclampsia. A more "honest" approach to the management of labor could significantly curb this trend. Perhaps we should ask the surgeon to explain why a cesarean delivery was performed in each case. I recall a departmental review in which a physician was asked why he performed cesarean delivery in the presence of adequate x-ray pelvimetry, which was performed because of the slow progress of labor. His answer: "Because I did not want to be sued down the line." Indeed, a most honest answer.

Another incident I recall is a snowstorm that prevented many doctors from reaching the hospital. The cesarean-delivery rate during that interval was 5% (perhaps the lowest in history!) without any untoward consequences to mothers and babies.[2]

We can expect that the rate of cesarean delivery will go down only when the physician's confidence of doing the right thing for the patient outweighs the risk of being sued.

Stefan Semchyshyn, MD
Jonesborough, Tenn

References

1. Barber EL, Lundsberg LS, Belanger K, Pettker CM, Funai EF, Illuzzi, JL. Indications contributing to the increasing cesarean delivery rate. Obstet Gynecol. 2011;118(1):29–38.
2. Semchyshyn S. Cesarean sections and acts of God. CMAJ. 1986;109:987.

Instant Quiz Answer

Answer to the instant quiz on page 11.

The 33rd President of the United States, **Harry S Truman**, was the first enrollee in Medicare. Truman's wife, **Bess**, was second. Both were handed their Medicare cards by President Lyndon Johnson at the signing of the Medicare bill into law, in 1965.