

“STOP USING RECTAL MISOPROSTOL FOR THE TREATMENT OF POSTPARTUM HEMORRHAGE CAUSED BY UTERINE ATONY”

ROBERT L. BARBIERI, MD (JULY 2016)

More on rectal misoprostol for postpartum hemorrhage

We applaud Dr. Barbieri’s July Editorial urging providers to stop administering misoprostol rectally for the treatment of postpartum hemorrhage (PPH) given the well-documented evidence and pharmacokinetics that recommend the sublingual route. Confusion among providers may derive from the fact that not all international guidelines, including the American College of Obstetricians and Gynecologists clinical guidelines on the management of PPH, have been updated to reflect the latest evidence.¹ Guidelines from the World Health Organization and the International Federation of Gynecology and Obstetrics reflect the latest evidence and clearly recommend the evidence-based regimen of 800 µg misoprostol sublingually for treatment of PPH,² which has been shown to be comparable to 40 IU oxytocin intravenously in women who receive oxytocin for PPH prophylaxis.³

Although oxytocin remains the first-line treatment for PPH, evidence suggests that sublingual misoprostol should be considered a viable first alternative if oxytocin is not available or fails. There is little evidence on the benefit of methergine or carboprost over misoprostol for PPH treatment, and inclusion of these drugs in treatment guidelines and practice is based on extrapolations from studies on PPH prevention.⁴ As Dr. Barbieri noted, pyrexia from misoprostol has been cited in the literature; however, contrary to contraindications for

methergine, for example, this rare event does not pose serious risks to women, is self-limiting, and appears to be most acute among certain populations.⁵

It is paramount that safe, effective, and evidence-based PPH treatments be available and known to providers both in the United States and globally in order to provide women with timely treatment. Greater discussion and research is warranted about the hierarchy of use for these drugs and the possible impact of routine use of uterotonics before and during delivery, given that overexposure to uterotonics may in fact be making PPH harder to treat.⁶

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References

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>> Dr. Barbieri responds

I thank Drs. Burkhardt and Dabash for sharing their expert perspective with our readers. They advocate for the use of sublingual misoprostol for the treatment of PPH “if oxytocin is

not available or fails.” I agree that at a home birth, if oxytocin is not available, sublingual misoprostol would be of great benefit. I remain concerned that misoprostol has little clinical utility for the treatment of PPH in the hospital setting in which oxytocin, methergine, and carboprost are available alternatives. Misoprostol causes fever in many women, and women who develop a postpartum fever due to misoprostol will receive unnecessary antibiotic treatment. I recommend that our readers stop using misoprostol for the treatment of PPH in the hospital setting.

“UPDATE ON CONTRACEPTION”

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(AUGUST 2016)

Interesting anatomic variation and management for IUD placement

I recently saw a patient for insertion of an intrauterine device (IUD). On examination with a speculum, I could not find the patient’s cervix. On bimanual exam, I found the cervix to be extremely anterior. I again placed a speculum and, even knowing where to look, could not bring the cervix into view. I did a second bimanual exam and noticed that I could move the cervix into a more axial plane if I exerted suprapubic pressure. The patient’s uterus was retroverted and her cervix was behind her symphysis. When I placed the speculum again, I asked the patient to apply suprapubic pressure, as I just had. With this procedure I then found her cervix easily, grasped it with a tenaculum, and inserted the IUD, which went well.

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