

“STOP USING INSTRUMENTS TO ASSIST WITH DELIVERY OF THE HEAD AT CESAREAN; START DISENGAGING THE HEAD PRIOR TO SURGERY”

ERROL R. NORWITZ, MD, PHD, MBA
(AUGUST 2016)

Patient positioning helps in managing impacted fetal head

As a general practice ObGyn, I have seen an increasing incidence of difficult cesareans as a result of prolonged second stage of labor. Dr. Norwitz cites this increase in his article. I have found that trying to elevate the fetal head prior to the start of surgery has been remarkably ineffective. In my practice, I place all my patients with second-stage arrest in low lithotomy stirrups (“blue fins”); this allows the nurses easier access to the vagina to elevate the head at surgery while I am reaching down from above. Usually, this facilitates delivery. It also allows better assessment of blood loss through the vagina as the cesarean progresses, and it makes placement of a Bakri balloon easier if necessary. If stirrups are not available, the patient can be placed in frog leg positioning so that my assistant can reach down and elevate the head if necessary. I find that in a patient with a very small pelvis, it is hard to get my hand down to the baby’s head. I have not yet done a breech extraction, but I know it is possible. I would probably try nitroglycerin first.

I think that difficult cesarean delivery is much more common than difficult shoulder dystocia, and we should develop standard procedures for addressing the issue and use simulation models to practice. In my time-out prior to surgery, I discuss my concerns so that everyone is ready for it, including the anesthesiologist/CRNA, and we have nitroglycerin available to relax



AUGUST 2016

the uterus if necessary. I hope that the American College of Obstetricians and Gynecologists (ACOG) will develop a committee opinion about this very important issue.

Marguerite P. Cohen, MD
Portland, Oregon

Assistant is key in disengaging fetal head

Disengaging the head by an assistant during a cesarean delivery is probably the most successful and useful method for managing an impacted fetal head at cesarean. The disengagement of the head prior to cesarean is practiced routinely in Europe, where forceps delivery is frequently performed. However, the disengagement should be done in the operating room (OR) just prior to or during the cesarean. To perform this in the delivery room, as suggested in Dr. Norwitz’s article, risks the associated fetal bradycardia due to head compression that might compromise an already compromised fetus. In addition, there is a risk of cord prolapse or release of excessive amniotic fluid resulting in cord compression.

Also, in many hospitals in the United States, there is some delay to perform the cesarean because the OR is on a different floor from the labor and delivery room and the OR staff come from home.

Vacuum extraction can be safely used for the extraction of the head if it is not possible to deliver it manually. However, the head should be manually disimpacted and rotated to occiput anterior prior to application of the vacuum. But the presence of caput might pose some difficulty with proper application and traction.

It is important to remember that the risk factors for an impacted fetal head are also risk factors for postoperative infection. Therefore, vaginal preparation with antiseptic solution should be considered prior to cesarean delivery for all patients in labor.¹

Raymond Michael, MD
Marshall, Minnesota

Reference

1. Haas DM, Morgan AI, Darei S, Contreras K. Vaginal preparation with antiseptic solution before cesarean section for preventing postoperative infections. Cochrane Database Syst Rev. 2010;3:CD007892.

Correction
“Comment & Controversy,”
OBG MANAGEMENT, September 2016,
page 14

Page 14 of the September print issue of OBG MANAGEMENT was incorrectly printed, leaving out the first page of Comment & Controversy with Letters to the Editor from E. Darryl Barnes, MD, Helio Zapata, MD, and the beginning of a letter from Federico G. Mariona, MD, that was completed on page 16. The complete Comment & Controversy section for September 2016 can be found online at <http://www.mdedge.com/obgmanagement/article/111311/obstetrics>.

—The Editors

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“PROTECTING THE NEWBORN BRAIN—THE FINAL FRONTIER IN OBSTETRIC AND NEONATAL CARE”
ROBERT L. BARBIERI, MD (AUGUST 2016)

Therapeutic hypothermia

I practice in a small community hospital without a neonatal intensive care unit (NICU). We have always paid attention to warming neonates. Although we cannot start neonatal therapeutic hypothermia, as Dr. Barbieri discusses in his August Editorial, would there be any benefit to avoiding purposefully warming infants who are depressed at birth? NICU care requires a pediatric transport team, which takes at least an hour to arrive.

Jane Dawson, MD
Maryville, Missouri

>> Dr. Barbieri responds

I thank Dr. Dawson for her observations and query. I agree that at a hospital without a NICU, pending the arrival of a pediatric transport

team, clinicians should strive to prevent hyperthermia in a newborn with encephalopathy because hyperthermia might exacerbate the ischemic injury. It may make sense to avoid aggressive warming of the newborn to permit the core temperature to decrease in order to begin the hypothermia process.

VIDEO: “LAPAROSCOPIC SALPINGECTOMY AND CORNUAL RESECTION REPURPOSED: A NOVEL APPROACH TO TUBAL OCCLUSION DEVICE REMOVAL”
MICHELLE PACIS, MD, MPH (JULY 2016)

Easier technique for removing tubal occlusion devices?

My patient’s rheumatologist recently asked me to remove the tubal occlusion device (Essure) inserts that I had placed approximately 5 years ago. I think the technique I used was a little easier than the one shown in

the video by Dr. Pacis and featured by Dr. Advincula in his video series. I started with a standard salpingectomy from the fimbriated end, as did the technique in the video. Then I made a circumferential incision of the tubal serosa at the junction of the tube as it enters the cornua, taking care to not cut the device insert, which could be visualized and felt with cold shears. The proximal end of the device insert, including the post and coil, then easily pulled out with some elongation of the coil. Since I did not need to resect the cornua, I was able to easily seal off the small defect without need to suture.

Alexander Lin, MD
Chicago, Illinois

>> Dr. Pacis responds

Thank you for sharing your method for tubal occlusion device removal. Your technique would certainly work for devices that reside predominantly in the tube. We have found that many of

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the devices become quite anchored and adherent to the tubal mucosa. While there are many surgical approaches to device removal, our preference is to perform salpingectomy with cornual resection, so as to avoid traction on the microinsert, and remove the device intact. We are then able to give the specimen, which contains the insert, to pathology so they can comment on the status of the device.

“UPDATE ON MENOPAUSE”

ANDREW M. KAUNITZ, MD (JULY 2016)

Menopause and hormone therapy

As a long-term believer (proven!) of the value of the old comment, “estrogen forever,” I was pleased to see all the positive comments about

estrogen in Dr. Kaunitz’s article. I was disappointed, however, in the comments in the box (page 39), “What this evidence means for practice.”

While my prejudice, statistically supported, is old fashioned, omission of the newer and marvelous way to counteract the only bad effects of estrogen (endometrial stimulation leading to endometrial adenocarcinoma) seems to be a major oversight. The new and least (if any) side-effect method means a levonorgestrel-releasing intrauterine device (LNG-IUD) yielding local progesterone counteraction to this major side effect of estrogen therapy.

Arthur A. Fleisher II, MD
Northridge, California

» Dr. Kaunitz responds

I thank Dr. Fleisher for his interest

in my 2016 Update on Menopause. I agree that off-label use of the LNG-IUD represents an appropriate alternative to systemic progestin when using estrogen to treat menopausal symptoms in women with an intact uterus.

WE WANT TO HEAR FROM YOU!

Share your thoughts on an article you read in this issue or on any topic relevant to ObGyns and women’s health practitioners.

We will consider publishing your letter in a future issue.

Contact us at
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Please include the city and state in which you practice.