

“LONG-ACTING REVERSIBLE CONTRACEPTIVES AND ACNE IN ADOLESCENTS”

ROBERT L. BARBIERI, MD, AND ANDREA H. ROE, MD (EDITORIAL; JANUARY 2017)

Manage acne with spironolactone for women on LARC

Dr. Barbieri’s editorial with Dr. Roe addressed the very important theme of proactively talking about acne before a patient starts long-acting reversible contraception (LARC), especially when switching from a birth control pill that had controlled the acne to a levonorgestrel intrauterine device (LNG-IUD). It missed the mark, however, in not mentioning a very important presenting feature of adolescent polycystic ovary syndrome (PCOS)—cystic acne. I highly recommend obtaining baseline testosterone levels and using spironolactone, 50 to 200 mg daily, to treat acne while on LARC, especially an LNG-IUD. I learned this trick a few years ago from a Canadian endocrinologist.

John Lewis, MD
Waterbury, Connecticut

» Dr. Barbieri responds

I thank Dr. Lewis for the important clinical pearl to use spironolactone to prevent and treat acne when inserting a progestin-releasing LARC in an adolescent or young woman. Spironolactone blocks testosterone action in the pilosebaceous unit, thereby decreasing sebum production and reducing acne activity. I frequently use spironolactone in my practice, especially for women with PCOS who have hirsutism and acne (see my editorial on page 8 of this issue). However, authors of a recent systematic review reported that there is minimal evidence from clinical trials to support the use of spironolactone to treat acne vulgaris.¹

Reference

1. Layton AM, Eady EA, Whitehouse H, Del Rosso JQ, Fedorowicz Z, van Zuuren EJ. Oral spironolactone for acne vulgaris in adult females: a hybrid systematic review. *Am J Clin Dermatol.* 2017;18(2):169–191.

“TRUST: HOW TO BUILD A SUPPORT NET FOR OBGYNs AFFECTED BY A MEDICAL ERROR”

PATRICE M. WEISS, MD (JANUARY 2017)

Support for ObGyn versus “evidence” for attorney

While every clinician recognizes the need to support the practitioner involved in a significant medical error, I found it puzzling that Dr. Weiss’ article did not mention our constant after-the-event associate, the personal injury attorney. How are we to provide the needed relief for the practitioner’s emotional distress without handing ammunition to the plaintiff’s lawyer?

E. Darryl Barnes, MD
Mechanicsville, Virginia

Experienced being the second victim

As Dr. Weiss states in her article, patients and their families, the first victims, are not the only ones affected by medical errors. I was involved in a medication error on a labor and delivery unit more than 20 years ago, and I was the second victim. There were also countless others. You are correct when you state that physicians, and others in medicine, do not support colleagues who have experienced a medical error. I agree with Dr. Wu’s observation that lack of empathy by peers is distressing. Symptoms of depression, burnout, decreased quality of life, and feelings of distress, guilt, and shame can occur in the second victim. I hope more people will get on board to use

The Joint Commission toolkit to assist health care organizations in developing a second-victim program.

Carol Permiceo, RN
Long Island, New York

» Dr. Weiss responds

I thank Dr. Barnes for his comments. The purpose of this article was mainly to assist people in establishing institutional support systems for providers when medical errors occur. Often we are not aware of litigation until some time well after the event. The TRUST second-victim support program and other programs are for immediate first aid for the provider and the team. Concerning the plaintiff’s ammunition, please remember that the purpose of these support systems, whether immediate or ongoing, is to discuss the emotional impact of the case on the provider, not the clinical details of the case.

I appreciate Ms. Permiceo sharing her story. As you probably have figured out, my interest in this area stems from my own experiences with medical errors (one in particular) and unanticipated outcomes. I hope by talking about it and validating our feelings (we are only human, after all) others will suffer less and come forward.

“MANAGEMENT OF WOUND COMPLICATIONS FOLLOWING OBSTETRIC ANAL SPHINCTER INJURY (OASIS)”

ROBERT L. BARBIERI, MD, AND JEANNINE M. MIRANNE, MD, MS (EDITORIAL; DECEMBER 2016)

Delivering clinician should be seated

Indeed, obstetric anal sphincter injuries (OASIS),¹ with their short- and long-term consequences, merit clinical attention, as spotlighted in

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Dr. Barbieri and Dr. Miranne's article. An issue not discussed is the position of the obstetrician.

In our practice, we sit down to perform a vaginal delivery, as taught by Soranus of Ephesus.² We strive to be at the bedside sooner than when the nurse calls "she is crowning." This allows communication with the woman, attending nurse, and support person(s), as well as for a brief review of recent estimated fetal weight, length of the second stage, position of the presenting part, degree of flexion, presence of caput, and other last-minute details. Sitting down in front of the outlet permits uninterrupted visual evaluation of the distention of the soft perineal tissues. All traditional maneuvers are performed comfortably from the sitting position: the vertex is controlled by hands-on, and a quick reach with the nonpredominant hand searches for a loop of cord or a small part proclivata to resolve it. The patient is coached either for the next bearing-down effort or to not push to allow for gradual, controlled delivery of the fetal shoulder girdle. We avoid use of the fetal head for traction and move to facilitate "shrugging" with reduction of the bisacromial to facilitate delivery.

In our experience, the sitting position is ideal to observe uninterrupted the tension of the perineal body during vertex and shoulders delivery, without having to flex and rotate our back and neck in repeatedly nonergonomic positions.

If an obstetrician of above-average height stands for the delivery, the obstetric bed should be elevated to fit her or his reach. Should shoulder dystocia occur, an assistant will stand on a chair and hover over the maternal abdomen to provide

suprapubic pressure (indeed, an indelible memory for any parturient and her family). From the sitting position, exploration of the birth canal and repair of any injury, if necessary, can be conducted without technical impediments.

These simple steps have provided our patients and ourselves with clinical and professional satisfaction with minimal OASIS events as shown by others.³ Ironically, if we successfully avoid perineal injuries, our young trainees may require simulation training to learn this tedious repair procedure. In our geographic practice area, a new "collaborative" expects the frequency of episiotomy to be less than 4.6%. Third- and 4th-degree spontaneous or procedure-related perineal injuries still are used to measure quality of care despite demonstrated reasons for this parameter to be a noncredible metric.

Federico G. Mariona, MD
Dearborn, Michigan

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1. Verghese TS, Champaneria R, Kapoor DS, Latthe PM. Obstetric anal sphincter injuries after episiotomy: systematic review and meta-analysis. *Int Urogynecol J*. 2016;27(10):1459-1467.
2. Drife J. The start of life: a history of obstetrics. *Postgrad Med J*. 2002;78(919):311-315.
3. Basu M, Smith D, Edwards R; STOMP Project Team. Can the incidence of obstetric anal sphincter injury be reduced? The STOMP experience. *Eur J Obstet Gynecol Reprod Biol*. 2016;202:55-59.

» Dr. Barbieri responds

I agree with Dr. Mariona that in some cases the fetal head delivers without causing a 3rd- or 4th-degree laceration, but then the delivery of the posterior shoulder causes a severe perineal injury. Dr. Mariona's clinical pearl is that the delivering clinician should be seated, carefully observe the delivery of the shoulders, and facilitate fetal shrugging by gently reducing

the bisacromial diameter as the posterior shoulder transitions over the perineal body.

"SHOULDER DYSTOCIA: TAKING THE FEAR OUT OF MANAGEMENT"

JOHN T. REPKE, MD, AND
RONALD T. BURKMAN, MD
(WEB EXCLUSIVE; APRIL 2016)

Montgomery maneuver for shoulder dystocia

In managing shoulder dystocia, my maneuver is to use my elbow to maximize mechanical advantage when applying suprapubic pressure to push the trapped shoulder down. It works well and is more efficient than having a nurse standing off to the side.

J.S. Montgomery, MD
Cypress, Texas



Photo courtesy of J.S. Montgomery, MD.

» Dr. Barbieri responds

I thank Dr. Montgomery for sharing his maneuver for dislodging the trapped anterior shoulder by using his elbow to apply suprapubic pressure. There is vast knowledge and experience in our clinical community, and sharing insights is helpful to all our readers.