

“START OFFERING ASPIRIN TO PREGNANT WOMEN AT HIGH RISK FOR PREECLAMPSIA”

ROBERT L. BARBIERI, MD
(EDITORIAL; MAY 2016)

When should we stop aspirin during pregnancy?

In his Editorial, Dr. Barbieri discusses the ideal time to start aspirin in women at high risk for preeclampsia, but does not identify when to stop this medication. At our community health center, we have been stopping oral aspirin 81 mg at 36 weeks’ gestation because of the “potential” for postpartum hemorrhage or intrapartum hemorrhage after this time. Is there any literature regarding the evidence behind this date?

Tammy R. Gruenberg, MD, MPH
Bronx, New York

>> Dr. Barbieri responds:

I appreciate Dr. Gruenberg’s important advice for our readers. Although low-dose aspirin is not known to be a major risk factor for adverse maternal or fetal outcomes, it is wise to stop the

therapy a week prior to delivery, to reduce the theoretical risk of postpartum hemorrhage. Stopping aspirin at 36 or 37 weeks’ gestation will ensure that the majority of women are not taking aspirin at delivery.

“INTRACTABLE SHOULDER DYSTOCIA: A POSTERIOR AXILLA MANEUVER MAY SAVE THE DAY”

ROBERT L. BARBIERI, MD
(EDITORIAL; APRIL 2016)

Another shoulder dystocia maneuver?

An additional technique that I use for managing shoulder dystocia is to simply track upward with the baby’s head, delivering the posterior shoulder without injury to the arm. Once the posterior shoulder clears the plane of the pubis and the anterior shoulder is mobilized, the posterior shoulder is rotated anterior in front of the pubic plane and the body unscrews itself from the pelvis. I also described this technique in a published letter to the editor in August 2013.

Dr. Barbieri’s suggestions in his April 2016 article are complicated for the less experienced ObGyn and could be dangerous for the baby (with potential fractures, nerve, and vascular injuries). Think about the described Gaskin maneuver: you flip the patient over on all fours, pull the baby’s head down, and deliver the superior shoulder (formerly the posterior shoulder).

Many obese and exhausted patients with epidurals will not be able to flip over for the Gaskin maneuver. The beauty of what I suggest is that this repositioning is not needed, and pulling on arms and axillae can endanger the baby.

Robert Graebe, MD
Long Branch, New Jersey

>> Dr. Barbieri responds:

I thank Dr. Graebe for describing his approach to resolving an intractable shoulder dystocia. Personally, I try to avoid applying force to the fetal head once a shoulder dystocia has been diagnosed.

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Preferred approaches to resolving the difficult shoulder dystocia

In his article, “Intractable shoulder dystocia: A posterior axilla maneuver may save the day,” which appeared in the April 2016 issue of OBG MANAGEMENT, Editor in Chief Robert L. Barbieri, MD, offered several posterior axilla maneuvers to use when initial shoulder dystocia management steps are not enough.

He indicated his preferred maneuver as the Menticoglou, and asked readers: “What is your preferred approach to resolving the difficult shoulder dystocia?”

Quick poll results

More than 100 readers weighed in:

- **33.6% (38 readers)** prefer the Menticoglou maneuver
- **21.2% (24 readers)** prefer the Schramm maneuver
- **19.5% (22 readers)** prefer the Holman maneuver
- **15% (17 readers)** prefer the Willughby maneuver
- **10.6% (12 readers)** prefer the Hofmeyr-Cluver maneuver

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