

WHAT IS YOUR APPROACH TO THE PERSISTENT OCCIPUT POSTERIOR MALPOSITION?

ROBERT L. BARBIERI, MD
(EDITORIAL; MARCH 2019)

A classic approach for managing fetal malposition

For those of us who trained and practiced obstetrics in the days of the 6% primary cesarean delivery (CD) rate, we never considered the management of the persistent occiput posterior (OP) position to be particularly difficult. I outline below a method that requires no unusual level of skill or dexterity.

1. The cervix must be fully dilated.
2. Dense regional anesthesia must be achieved.
3. The vertex must have reached +1 station.
4. The position must be clearly established, and this does not require anything other than the ability to palpate an ear, as it can be pointed only in one direction. If you feel ultrasonography is needed, be my guest.
5. Use an obstetric lubricant to reduce resistance and minimize lacerations.
6. While a trial of manual rotation is reasonable, it commonly will not succeed and requires that an operator's hand be inserted rather than a slender and less traumatic device (forceps).
7. Next, palpate the sagittal suture to determine whether the position is straight OP versus left OP or right OP. This should not be difficult unless the poor woman has gone through 2 or 3 hours of unproductive pushing, thereby creating caput.
8. After proper forceps application is confirmed, gently apply upward pressure. This will make rotation easier.
9. Dr. Irving's recommendations



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notwithstanding, the forceps handles are not carried in a wide sweep. One should use Kielland's forceps, which do not have a pelvic curve and were invented for this precise indication. The forceps are simply rotated.

10. Try to avoid delivery as an OP, as this pulls a much larger diameter deflexed head through the pelvis and usually results in significant lacerations.
11. Episiotomy is not always required if rotation has succeeded.
12. Once descent to the outlet has been achieved, it is probably best to switch to a forceps with a pelvic curve to achieve easier extension.
13. This should complete the delivery, but as a general rule, if more than minimal resistance is met in any of the above steps, abandon the procedure and move to CD.
14. This process should result in at least a 70% success rate.

As is most likely understood by the current generation of obstetricians who appear to be satisfied with a 30% to 40% primary CD rate, the above reflects the views of a

long-retired ObGyn (whose CD rate never exceeded 10%) and may be inappropriate for those who are not adequately trained in or comfortable with vaginal obstetrics.

David M. Priver, MD
San Diego, California

HOW DO YOU FEEL ABOUT EXPECTANTLY MANAGING A WELL-DATED PREGNANCY PAST 41 WEEKS' GESTATION?

ROBERT L. BARBIERI, MD
(EDITORIAL; FEBRUARY 2019)

Membrane stripping can be problematic

The recent discussion on stripping membranes to facilitate the initiation of labor and delivery was intriguing. This practice was reviewed extensively during my training in the 1960s and abandoned when the results were disappointing or contradictory. Although the practice has been revitalized recently, I am concerned that potential risks and the absence of a recommended protocol of safeguards may allow new problems to develop.

In a metropolitan community where I provide consultative services, the only patients I see for evaluation of pregnancies beyond 40 to 41 weeks come from providers who are non-physicians. Apparently, they are concerned that they may have to turn their patients over to physician providers for interventions that they are not capable of doing. My advice to them is simply that nothing good happens after 40 to 41 weeks.

Well-grown babies may continue to grow if they are healthy, and they may incur greater risks of dystotic labor and delivery resulting in injury or the need for physician-administered surgical assistance. If, on the other hand, growth markedly diminishes or ceases, fetal harm or

neonatal complications may occur through asphyxia, meconium aspiration, or trauma. In either event, physician-based assistance is strongly encouraged, as long as due diligence in determining gestational age has been done.

Promoting membrane stripping without having a protocol for ascertainment of risk factors is worrisome to me. In my opinion, large population studies that fail to demonstrate increased risks of infection may fail to demonstrate that membrane stripping may induce a degree of perinatal infection comparable to that of prolonged labor with multiple internal examinations with or without ultimate cesarean birth. Prior to considering membrane stripping as a strategy, one should recognize certain important considerations, namely:

- Patients most in need of active

intervention may have the least favorable cervical findings, and as a result they are potentially at risk for the greatest discomfort.

- The frequency of group B streptococcal colonization of the vagina at term should be recognized, and a culture should be obtained immediately prior to intervention. When a culture is a positive, membrane stripping should be avoided, or at least a sober consideration of its use and appropriate antibiotic coverage should occur.
- Consider performing transvaginal ultrasonography prior to membrane stripping to exclude the possibility of a placental edge close enough to be encountered and compromised, with resultant hemorrhage in an outpatient venue ill equipped to provide adequate emergency support.
- The comparative effectiveness of

other direct cervical conditioning therapies, including use of a Foley catheter or regional prostaglandin medication, has been well explored and found effective. Also, if one takes seriously the need for any intervention, admission to the hospital for overnight cervical conditioning allows for surveillance and avoids the patient experience of being sent home cramping, bleeding, brooding infection, and questioning her trust in the provider.

I am concerned that the promotion of this potentially rather brutish practice by highly reputable advisors can result in its growing utilization by providers some of whom may be least qualified to apply proper judgment and sensitivity to its selection. In the most primitive of circumstances, it may have utility. Personally, however, I feel that medically based

Appropriateness of performing in-office uterine aspiration

In their article, "Uterine aspiration: From OR to office" (February 2019), Lauren Thaxton, MD, MBA, and Bri Tristan, MD, made the case for why, in appropriate clinical situations, office-based uterine aspiration, compared with uterine aspiration in the OR, should be the standard surgical management of early pregnancy failure. Their reasons included an equivalent safety profile, reduced costs, and patient-centered characteristics.

OBG MANAGEMENT posed this query to readers in a website poll: "Should the standard location for uterine aspiration be in the office?" See how readers responded, below.

Poll results

A total of 73 readers cast their vote:

- **86.3% (63 readers)** said yes, in appropriate clinical situations
- **13.7% (10 readers)** said no

Reader comments

"Yes, in appropriate clinical situations."

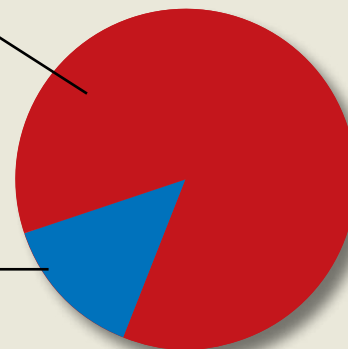
-Yardlie Toussaint-Foster, DO, Downingtown, Pennsylvania

"I have been doing it this way (in the office) for years, up to 11 to 12 weeks without complication."

-John Lane, MD, Raleigh, North Carolina

Uterine aspiration should be done in the office in appropriate situations
86.3%

Uterine aspiration should not be done in the office
13.7%



strategies initiated and monitored by professionals capable of dealing with any untoward departures from the expected results must be considered in the best traditions of what we do. The appeal of simplicity must not encourage the adoption of interventions that lack the proper application of thought and plan and whose

only appeal is that of simplicity.

Richard P. Perkins, MD

Fort Myers, Florida; Stockton, California

Dr. Barbieri responds

I thank Dr. Priver for his excellent description of how to use forceps to resolve a persistent occiput posterior position. I also thank Dr. Perkins for

his valuable comments and agree with him that in the United States among the options available for outpatient cervical ripening, misoprostol or a balloon are more commonly used than membrane stripping. Membrane stripping is an outpatient cervical ripening technique that is commonly used in the United Kingdom.