A VBAC question

To the Editors: The article by Blanchette et al[1] proved thought provoking. Contained within were seven points that can be used as a guide toward a safe vaginal birth after prior cesarean section. These points were presented in a clear and pragmatic manner. The danger with an article that makes one think is the questions that arise in the reader's mind. One question would be, why not add pelvic assessment?

The use of x-ray pelvimetry to assess the pelvis can be argued against by use of literature examples, such as increased cesarean section rate or fetal damage. Use of this technique either before pregnancy or just after the first cesarean section would be one way around some of these arguments. Another would be the use of the De Lee pelvimeter to measure anteroposterior diameter at the time of the first cesarean section as part of the pelvic assessment. This simple instrument does not add the risk of an x-ray technique and provides a quantitative measure that can be used to guide future decision making.

Jorge O. Escamilla, MD

204 Sunset Dr, Brooksville, FL 34601

REFERENCE

1. Blanchette H, Blanchette M, McCabe J, Vincent S. Is vaginal birth after cesarean safe? Experience at a community hospital. Am J Obstet Gynecol 2001;184:1478-87.

6/8/121658
doi:10.1067/mob.2002.121658

Reply

To the Editors: In response to Escamilla's recommendation that pelvic assessment be added to the list of seven optimal conditions for a safe and successful trial of labor after cesarean section, we would suggest that the use x-ray pelvimetry or the De Lee pelvimeter may not be helpful. The prognosis for successful vaginal delivery in any given pregnancy cannot be established on the basis of x-ray pelvimetry alone because the pelvic capacity is but one of several factors that determine the outcome.[1] Additionally, 50% to 70% of patients with a prior cesarean section for dystocia are successfully delivered vaginally after a trial of labor after prior cesarean section. A clinically adequate pelvis is one of the current criteria useful in identifying candiates for vaginal birth after cesarean section.[2]

Howard Blanchette, MD

Department of Obstetrics and Gynecology, Danbury Hospital, 24 Hospital Ave, Danbury, CT 06810

REFERENCES

1. Cunningham, et al. Williams' obstetrics. 21st ed. Dystocia: abnormal and fetopelvic disproportion. New York; McGraw-Hill; 2001. p. 438.
2. Vaginal birth after previous cesarean delivery. Washington (DC): American College of Obstetricians and Gynecologists; 1999. ACOG Practice Bulletin No.: 5.

6/8/121657
doi:10.1067/mob.2002.121658

Obstetrician-gynecologists performing genetic amniocentesis may be misleading themselves and their patients

To the Editors: We are writing to confirm and support the observations of Blessed et al.[1] We have reviewed the experience with genetic amniocentesis at Phoenix Perinatal Associates. From August 1999 to June 2001 we performed 1496 midtrimester amniocenteses for genetic diagnosis. There were three losses within 2 weeks of the procedure, for a loss rate of 1:499. Seventeen patients had postprocedure leaking of fluid, which resolved, and the pregnancy continued without problems.

We support the authors' conclusion that, in the hands of physicians doing large numbers of procedures, genetic amniocentesis is safer than previously published studies have suggested.

William H. Clewell, MD, Ann Bogle, PhD, Nicole Weston, MS, and Susan Greensher, MS

Division of Maternal-Fetal Medicine, Good Samaritan Medical Center, 1111 E McDowell Rd, Phoenix, AZ 85006

REFERENCE

1. Blessed WB, Lacoste H, Welch RA. Obstetrician-gynecologists performing genetic amniocentesis may be misleading themselves and their patients. Am J Obstet Gynecol 2001;184:1340-4.

6/8/121655
doi:10.1067/mob.2002.121655

Reply

To the Editors: We thank Dr Clewell for his letter supporting our study and conclusions. Our study confirms previous reports that increased experience in performing invasive procedures is associated with fewer complications. Since the publication of our findings, other groups confirming our findings have contacted us. We hope that our study stimulates clinicians to critically evaluate their own performance to determine whether they are really providing the best care or if they are "misleading themselves and their patients."

William B. Blessed, MD, and Robert A. Welch, MD

Providence Maternal Fetal Diagnostic Centers, Providence Pavilion, 22255 Greenfield Rd, Suite 350, Southfield, MI 48075

6/8/121656
doi:10.1067/mob.2002.121655

Low maternal plasma volume may be the answer!

To the Editors: Bukowski et al have shown that a significant proportion of fetuses destined for preterm delivery do not reach their growth potential, a relationship that was previously proposed.[1,2] The authors have ignored the concept that this relationship might represent two effects of inadequate maternal plasma volume expansion.[2] Failure to adequately expand maternal plasma volume has several additional clinical symptoms, including hemoconcentration (high hematocrit) and decreases of amniotic