Maternal mortality in the United States: predictability and the impact of protocols on fatal postcesarean pulmonary embolism and hypertension-related intracranial hemorrhage

TO THE EDITORS: I applaud the work that Clark et al[1] are doing and sharing to decrease maternal mortality. Their approach will hopefully make pregnancy and delivery safer for more and more women. Although I am enthusiastic about their work, if I review their article in a scientific fashion, I have concerns about their conclusions.

I do not believe that the authors' conclusions can be made using their study design. In their investigation of fatal postcesarean pulmonary embolism, the authors only looked at mortality data and not total postcesarean pulmonary embolism incidence data. I can think of other explanations that can account for the decrease in deaths from postcesarean pulmonary emboli. One possible explanation is an improved awareness of the risk of postcesarean pulmonary embolism and thus earlier diagnosis and earlier initiation of treatment. Another possibility is the use of improved and/or more aggressive treatment regimens for patients with postcesarean pulmonary emboli. To state that the policy of universal use of pneumatic compression devices "resulted in" or "reduced dramatically" fatal postcesarean pulmonary emboli is overreaching. A more appropriate conclusion would be that the authors' protocol is correlated with a decrease in fatal postcesarean pulmonary embolism.

I endorse the use of venous thromboembolic prophylaxis for women undergoing cesarean delivery. Currently, I do not know what the optimal prophylaxis strategy is. I am concerned that premature conclusions about the efficacy of any strategy may blunt our advancement in the safe care of women. ■

Leo R. Brancazio, MD
Duke University Hospital
Division of Maternal-Fetal Medicine
Department of Obstetrics and Gynecology
Duke University Medical Center
Durham, NC
leo.brancazio@duke.edu

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REPLY

Dr Brancazio's tautologic observation is of course correct; in the absence of multiple prospective, randomized, double-blinded, placebo-controlled crossover trials, or the fulfillment of Koch's postulates, it is difficult to categorically prove a cause-and-effect relationship in medicine. Unfortunately, this shortcoming applies to most treatments currently in use in clinical obstetrics. However, when one applies a technique proven to reduce pulmonary embolism by about 70% in most other areas of surgery to cesarean delivery, and finds about a 70% reduction in deaths from pulmonary embolism in the years immediately following this change with an N >1 million in study and control groups, it is reasonable to infer a causal connection, particularly when available diagnostic and therapeutic tools were the same in both time periods. ■

Steven L. Clark, MD
James T. Christmas, MD
Hospital Corporation of America
Nashville, TN
Steven.clark1@hcahealthcare.com

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Complications following "Brazilian" waxing for pubic hair removal

TO THE EDITORS: We read with interest the article by Demaria et al[1] as pubic hair removal has gained more popularity in recent years. Various methods of hair removal may also be associated with sexually transmitted diseases. Primary genital herpes from contamination from a waxing salon has been described in the literature.[2] Cases of

molluscum contagiosum outbreak and septic shock due to staphylococcal infection are yet other complications of pubic waxing.[3] Contamination of waxing tools such as a spatula from a previously infected patient or the individual performing it rather than the waxing tub are more likely causes of transmission of herpetic infection, or even a shingles outbreak in a patient under significant stress. Although reduction in pubic lice as a benefit of pubic hair removal has been reported in Britain,[3] herpes simplex following Brazilian waxing is an important concern in immunocompromised patients.[4]

Laxmi V. Baxi, MD
Margaret Dziadosz, MD
New York University Langone Medical Center
New York University School of Medicine
New York, NY
baxilax@gmail.com

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REPLY DECLINED

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