TO THE EDITORS: We appreciate the thoughtful review and recommendations of the Society for Maternal-Fetal Medicine’s “Consult Series #51: thromboembolism prophylaxis for cesarean delivery.” For women with class III obesity receiving pharmacologic thromboprophylaxis following cesarean delivery, the authors recommended an intermediate dose of enoxaparin (40 mg every 12 hours). In addition, the authors recommended a waiting period of 24 hours following neuraxial analgesia before initiating an intermediate-dose regimen. These recommendations mirrored those in Table 4 of the 2018 American College of Obstetricians and Gynecologists’ “Practice Bulletin no. 196: thromboembolism in pregnancy,” which itself was adapted from the 2018 Society for Obstetric Anesthesia and Perinatology (SOAP) consensus statement. Interestingly, although the SOAP consensus statement made timing recommendations for initiating low-dose enoxaparin (≥12 hours from neuraxial blockade) and therapeutic-dose enoxaparin (≥24 hours from neuraxial blockade), it made no specific timing recommendations for initiating intermediate-dose enoxaparin.

Regardless of the source of this recommendation, we would offer an alternative dosing regimen for intermediate-dose enoxaparin that would allow higher-risk patients with class III obesity to receive thromboprophylaxis more proximate to their surgical immobilization. Given that the first dose of enoxaparin (40 mg) in the intermediate regimen is the same as that of the prophylactic regimen, we propose administering the first intermediate dose 12 hours after neuraxial blockade, with the second dose administered 12 hours later. In this manner, the higher intermediate level of enoxaparin would not be reached until at least 24 hours from neuraxial blockade, which would satisfy concerns about spinal and epidural hematomas.

We welcome the authors’ expertise and guidance on this challenging issue.

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**Thromboprophylaxis following cesarean in women with class III obesity: a proposed alternative dosing regimen**

**REFERENCES**


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TO THE EDITORS: We read with concern the recent "Association of abnormal first stage of labor duration and maternal and neonatal morbidity." The question is about the authors’ choice to compare a variable (in this case labor duration) with outcomes related to a complex event, such as childbirth. Because of the retrospective nature of the study, classifying first stage of labor duration as an independent variable may lead to incorrect considerations. In fact, the association between the duration of first stage of labor and maternal morbidity is namely an association and does not mean a causal relationship. It is obvious that if we select a population of women with a longer labor, such as in this group, we would find a greater number of maternal or neonatal adverse outcomes. However, the point is we should not mistake causes for effects, as the pathologic outcomes are probably not due to the longer duration of labor. It is rather a longer length of labor that, conversely, has an underlying cause that should be identified, which results in a prolonged labor progression and leads to the complications observed. This logical problem suggest that the conclusions reached by Blankenship et al. that "[the] benefit of expectantly managing a prolonged first stage of labor with duration above the 90th percentile in anticipation of vaginal delivery must be weighed against the increased risk of composite maternal and neonatal morbidity" are wrong. We have previously shown that if the emphasis is on the diagnosis of the causes of slowdown in labor and not on the duration of labor per se, obstetricians can intervene to correct the probable etiologic causes. Furthermore, we reported that adverse outcomes remained unchanged. (ie, they do not depend on time) and that iatrogenicity was greatly reduced (cesarean deliveries, vaginal operative births, oxytocin augmentation). Essentially, cervimetric curves should be used as a screening test for dystocia in labor and not as a diagnostic tool. The groups discussed in the above definition, 90th and 10th percentiles, represent the levels of the independent variable, whereas the variable examined across the groups is known as the dependent variable. The problem is that waiting cannot be considered a therapy per se; time must be used to make a diagnosis instead, even if only a presumptive one, and to develop an etiologic therapy. In this way, as we have shown, we can reduce iatrogenicity without worsening birth outcomes by allowing women to express their potential to give birth and achieve a positive childbirth experience.

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