ultrasonography in the assessment of different aspects of fetal growth in both the second and third trimesters.

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6/8/82735

Reply

To the Editors: We appreciate your interest on our study of fetal lung volume estimation by three-dimensional ultrasonography. The question on performance of three-dimensional ultrasonography in cases of low contrast (e.g., oligohydramnios) is of significance for this technique. The technical equipment has developed fast, and imaging quality is even sufficient in cases with oligohydramnios. This allows application of this technique also in cases with low contrast. We already are using three-dimensional lung volume estimation in selected abnormal cases in prenatal diagnosis. Although many of these cases had oligohydramnios, we could easily estimate fetal lung volume in most cases. The results of this measurements have correlated with the clinical outcome. We need far more cases to give qualified answers to the question of clinical usefulness.

We pointed out that long acquisition times limit the application of magnetic resonance imaging in prenatal diagnosis. Of course, echoplanar magnetic resonance imaging can eradicate this limitation. However, this technique is not available in our university hospital and only very few centers around our country can provide it. We think that this lack of centers equipped with echoplanar imaging, is true in many European and overseas countries. Another problem when echoplanar imaging is used in obstetrics is the lack of detailed studies of possible hazard effects of magnetic resonance imaging to the fetus. This always raises discussion regarding this issue. For example, the company that produced the magnetic resonance imaging equipment in our hospital suggests not using it during pregnancy. In contrast, three-dimensional ultrasonography is approved in obstetrics and can even reduce the exposition of the fetus to ultrasound.[1, 2] We think that today both three-dimensional ultrasonography and echoplanar imaging could give important additional information to the physician and that in future the general availability of these techniques as well as aspects on safety and costs will decide which imaging technique will gain importance for routine use.

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6/8/82734

A new ethical and clinical dilemma in obstetric practice: Cesarean section "on maternal request"

To the Editors: The recent article by Pinkerton and Finnerty (Pinkerton JV, Finnerty LL. Resolving the clinical and ethical dilemma involved in fetal-maternal conflicts. Am J Obstet Gynecol 1996;175:289-95) outlines the possible ethical conflict between the patient's right to autonomous decision and the physician's right to autonomy in practicing according to acceptable procedures, and many examples are discussed of patients who refuse intervention. Our experience is paradoxically opposite.

In Italy, the Regione Marche, where our Department of Obstetrics and Gynecology of the University of Ancona is located, has been ratified the law on the rights of pregnant women[1] that "warrants the active participation of pregnant woman in (decision making during) all the stages of labor and delivery, and in the choice of the route of delivery." The knowledge of the rights that such law grants pregnant women led some of them to demand elective cesarean section, avoiding labor and every risk that they believe—properly or not—may be related to labor and vaginal delivery.

Last year therefore (the first year of wide application of "law 23") we first observed the phenomenon of elective cesarean section "on maternal request" as a small but not negligible (4%) part of the indications. Such indications, although not necessarily justified by obstetric conditions, cannot be considered an example of "bad medicine" but pose new and wider borders to our practice and allow room for ethical and legal discussion.

We strongly support patients' right to autonomy, but we foresee that special considerations will have to be given in assessing the standards of care because that will possibly cause a change in health care management by increasing the rate of cesarean section, while there is a general attempt to reduce it to the real obstetric need, or a clinical conflict in special issues, such as that of a multiparous patient who fears to labor again and refuses to be delivered vaginally. Although these are now iso-