

dialogue



Washington State Obstetrical Association
Washington Section, American College of Obstetricians and Gynecologists

September 2008

Why family practice physicians should practice obstetrics

By Susan McDonald
President
Washington State Obstetrical
Association

One of my obstetrical patients recently asked me if I liked delivering babies. It made me think. I really do, but not just for the delivery-room high of "Here's your baby." I like the challenge, the opportunity and the responsibility. Ob care offers a unique opportunity to witness family dynamics and bond with patients and family members. I continue to deliver babies as part of my family medicine practice because for me it puts the family in the medicine I practice.

Nationwide, only 25% of family medicine providers offer obstetrical care and many ob residency programs are struggling to fill each year. This, while access to maternity care is limited. I want to encourage residents and newly establishing providers to re-consider obstetrics. Here are some of the reasons why.

You may be the first and only opportunity this woman has for medical care. Many of my patients have medical coverage only if they are pregnant. They may never have been offered HIV, HSV or bacterial STD testing. They may never have had the chance to discuss contraception options in a private setting.

You could be the first person to diag-

nose depression, acne, diabetes or hypertension. You could change her life by treating these problems. You could be the person who warns her to make lifestyle, diet and exercise changes to avoid the future morbidity and mortality some of these diagnoses bring.

You could be the first person to tell her that nobody deserves to be hit. *You* could change her life and the life of her children—just by practicing obstetrics before you ever get to the delivery room.

I am not naive but I do believe that occasionally, every once in awhile, I change the future. And every time I attend the WSOA annual meeting, I am reminded of this challenge, opportunity and responsibility. I am re-energized to offer the best care I can and I am re-educated on the latest topics in obstetrics and gynecology

Why family practice . . .

Continued on page 2

Tobacco Quit Line expands services for pregnant women

Each year in Washington, about 8,700 babies are born to women who smoked during their pregnancy. The Washington State Department of Health's free Tobacco Quit Line now provides extra follow-up calls to help pregnant women increase their chances of quitting and remaining tobacco-free after the baby is born. Tobacco quit coaches have received additional training to better understand the challenges pregnant women face when trying to quit smoking.

The quit line is 1-800-QUIT-NOW, and in Spanish, 1-877-2NO-FUME. Pregnant women can also receive free nicotine replacement medications.

Tobacco Quit Line . . .

Continued on page 2

10 Eldorado Drive
Mercer Island, WA 98040

Pre-Sorted Standard
U.S. Postage
PAID
Seattle, WA
Permit No. 1445

Update on HPV, flu vaccines: hints for the busy ob gyn

The next generation of preventive gynecologic medicine is here: we can now help our patients reduce the risk of cancer. Immunizations aren't just for babies and the elderly anymore.

HPV vaccines

As you know, the quadrivalent HPV (human papillomavirus) vaccine is now recommended for teen women to help to lessen the risk of cervical cancer.

For many young women, however, the cost of approximately \$360 per three-dose series is prohibitive. To help out, the Seattle King - County Public Health Department is offering this vaccine at no cost to females aged 9-18 years through the Washington State Vaccines for Children Program. For information on the program, go to www.metrokc.gov/health/immunization.

In addition, Merck is now offering vaccine free to low income, uninsured, and under-insured females aged 19-26 who cannot afford the HPV vaccine without assistance. Licensed prescribers and their office personnel can obtain applications for

patients by going to www.merck.com/merckhelps/vaccines/home.html and clicking on "how the program works." Once the application is faxed back, Merck's goal is to process it and notify the prescriber in less than 10 minutes so that the patient can receive the vaccine during that visit.

Flu vaccines

Did you know that the CDC now recommends that *all* pregnant patients, regardless of their gestational age, get a flu shot? In Washington

Free HPV vaccine is available to young women.

State, flu shots in pregnancy must be preservative free. The 2007 legislature passed the "Children's Safe Products Act" prohibiting medical therapies containing mercury in pregnancy. Since thimerosal, the most common injectable preservative, contains mercury, physicians and clinicians should recommend mercury-free preservative-free flu immunization for patients in Washington.

More on immunizations in pregnancy

For physicians: <http://www.cdc.gov/vaccines/pubs/preg-guide.htm>.

For patients: http://www.cdc.gov/nip/publications/flyers/f_preg.pdf. □

Tobacco Quit Line . . .

Continued from page 1

Materials to help you talk with patients about tobacco are available at <http://www.quitline.com/reasons/qyq2/>. For more information or to order materials, contact Julie Thompson at Juliet.Thompson@doh.wa.gov. □

Why family practice . . .

Continued from page 1

each year. Join me December 5-6 at the WSOA meeting in Seattle and see for yourself. Give obstetrics a second look. It could change your life. □

WSOA Annual Meeting

Fairmont Olympic Hotel, Seattle, December 5-6, Preliminary Program
FRIDAY, DECEMBER 5

7:30 AM Registration/Continental Breakfast

8:00-8:10 Welcome/Introduction

8:10-9:00 **Blood Product Refusal: Considerations for Obstetric & Gynecologic Patients**
LaVone Simmons, MD

9:00-10:00 **Prevention and Treatment of Obstetric Hemorrhage**
Thomas J. Benedetti, MD

10:20-11:20 **Transfusion Management of Obstetric Hemorrhage**
Evelyn Lockhart, MD

Noon Lunch - **Womanly Mysteries: Some Things We Don't Know About Female Sexuality** David P. Barash, MD, PhD

1:10-2:10 **Pathogenesis of Preeclampsia** S. Ananth Karumanchi, MD

2:30-3:20 **Maternal Deaths in Washington** Cathy Wasserman, PhD, MPH

3:20-4:10 **Maternal Health in the Developing World** Frances Donnay, MD, Gates Foundation

6:30-7:30 Reception, Dinner

SATURDAY, DECEMBER 6

7:30-8:15 ACOG Business Meeting

8:30-9:20 **This Is Not Your Mother's IUD: An Update on Intrauterine Contraception**
Sarah W. Prager, MD

9:20-10:15 **The Safety, Efficacy and Acceptability of Over-the-Counter Provision of Combined Oral Contraceptives** Daniel Grossman, MD

10:30-11:20 **Reproductive Rights: A Status Report** Steward M. Jay, JD

WSOA Annual Meeting
Continued on page 4

dialogue

Published quarterly by the Washington State Obstetrical Association and the Washington Section, American College of Obstetricians and Gynecologists.

Thomas J. Benedetti, MD, Seattle, Editor

Jane Dimer, MD, Seattle, Chair, Washington Section, American College of Obstetricians and Gynecologists

Susan McDonald, MD, Puyallup, President, Washington State Obstetrical Association

Please mail correspondence to:
10 Eldorado Drive Mercer Island WA 98040. Phone (206) 232-9517; fax (206) 230-9159; e-mail WSOA@comcast.net.

A LOOK AT THE LITERATURE . . . FROM THE EDITOR

“Pitting to distress”

By Thomas J. Benedetti, MD, MHA

I have always been amazed that while obstetricians use oxytocin in more than 50% of all laboring patients, we know surprisingly little about the clinical pharmacology of this drug. Protocols vary regarding the starting dose, maximal dose to use and how fast to increase the dose. In most obstetrical units physicians just write the order for “pit by protocol” and leave the rest up to the nurse. Worse, it is almost entirely a nursing decision about when to decrease the oxytocin.

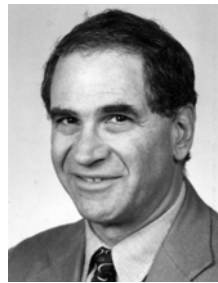
The terms hyperstimulation—contractions >5/10 minutes with fetal heart rate changes—and tachysystole—contractions >5/10 minutes—are often used interchangeably. Exactly what to call excess uterine activity has been modified over the last decade and are about to be changed again. There are few good clinical guidelines regarding when to stop or decrease the oxytocin short of obvious fetal compromise, which as most of us know, is often in the eye of the beholder. What looks abnormal in the light of day or after a poor outcome often was judged to be more benign when it actually happened. I recall reviewing a record many years ago in which the physician actually wrote, “Increase pitocin until contractions every two minutes or until signs of fetal distress.”

In large part because of the desire to optimize the chances of a vaginal delivery, many of us have been willing to “crank up the pit” or tolerate contractions of 5 or greater in 10 minutes in the absence of abnormal fetal heart rate changes.

There are two recent studies that provide some important information to help us better understand the optimal use of oxytocin. The first pub-

lished over a year ago evaluated the relationship between uterine activity and fetal acidosis. Of more than 1400 patients with pH determinations at birth, 5% were acidotic. Acidosis was defined as $pH < 7.11$ and could be respiratory (39%), metabolic (31%) or mixed (30%). The last hour of the first stage and the complete second stage of labor were evaluated.

In the first stage, all contraction variables between the acidotic and the non-acidotic group were statistically different. The acidosis group



When labor has been induced, oxytocin should be discontinued when 5 cm is reached.

had less relaxation time, longer contractions, higher amplitude, and a greater contraction frequency.

In the second stage, there was less relaxation time, higher amplitude and greater contraction frequency in the acidosis group. The amazing part of this study was the observation that both the acidotic and non-acidotic groups had similar frequencies of late decelerations in the time periods studied. Unfortunately, the actual incidence of abnormal fetal heart rate changes was not reported.

The second study reevaluates an issue I recall reading about over 25 years ago and which neither the author nor I can find in the literature. The study asks whether pitocin needs to be continued once active labor has been established. The study I recall from 25 years ago said no. This study reached the same conclusion. Patients whose labor was being induced were randomized to either continuation or cessation of oxytocin once 5 cm had been reached.

There were 170 patients in each group; more than 60% in each group were nulliparous. In the oxytocin-discontinued group the incidence of UC 6 or greater per 10-minute period was 8% versus 17% for the oxytocin-continued group ($p < 0.05$). This difference was entirely explained by the difference in parity (nulliparous 6% versus 20%, multiparous 13% versus 12.5%). The C section rate for the discontinued group was 4.8% versus 6.9% for the continued group ($p > 0.05$). Low 5-minute Apgar score (less than 7), $pH < 7.10$, and neonatal indicators did not differ between the groups, but the study was not powered to detect differences in these outcomes. Oxytocin need to be restarted in 11/160 patients (7%) and oxytocin was stopped in 8/162 patients (5%) because of abnormal fetal heart rate patterns.

In my mind there is enough evidence in these two studies to seriously consider changing our practice with reference to oxytocin use after 5 cm in patients undergoing labor induction. When labor has been induced, oxytocin should be discontinued when 5 cm is reached.

There is no apparent harm in this action as C-section rates did not increase in this study and few needed it restarted. Since 20% of primigravid patients will experience hyperstimulation without discontinuation and since hyperstimulation even without abnormal fetal heart rate patterns is associated with increased incidence of fetal pH less than 7.11, this action seem to me like a “no brainer.”

Sources

Bakker PC, Kurver PH, Kuik DJ, Van Geijn HP. Elevated uterine activity increases the risk of fetal acidosis at birth. *Am J Obstet Gynecol.* 2007 Apr;196(4):313.e1-6.

Ustunyurt E, Ugur M, Ustunyurt BO, Iskender TC et al. Prospective randomized study of oxytocin discontinuation after the active stage of labor is established. *J Obstet Gynaecol Res.* 2007 Dec;33(6):799-803. □

WACO G NOTES What do we in ob gyn do next?

Time to create a vision for our future

By Jane Dimer, MD
Seattle

"Our iceberg is melting," said Fred the penguin. Fred was a scientist; on his metaphorical iceberg, he toted a briefcase full of scientific observations, ideas and conclusions. The information that Fred was collecting over the last years was beginning to cry out: while that iceberg that had been there for many, many years was about to experience a profound change.

Hmmm, I thought . . . Welcome to our iceberg. John Kotter and Holger Rathgeber use a powerful metaphor in their book *Our Iceberg is Melting: Changing and Succeeding Under Any Conditions* to make valid points about the challenges of change. Written in a simple and humorous way—the characters are all penguins—they describe the key issues of coping with a fast-altering world; most importantly, they invite the reader to embrace and succeed in an era when things just aren't staying the same.

We've all noted that the practice of obstetrics and gynecology is changing. We are being significantly affected by increasing regulatory oversight, declining in reimbursement, and rising expectations of our patients fostered in web-based, media-driven communities. Too, the composition of our specialty has reached a tipping point: the majority of young ob gyn fellows is now women; their desires in work-life are evolving; and the way that our ob gyn colleagues are creating clinical groups is changing.

Health care in the U.S. is being transformed gradually and in piecemeal fashion. Health care reform on a national scale is one of the central

issues in this year's presidential election, notably among Democrats but Republicans, too.

During our annual visit to Washington, DC in February, your ACOG State Section representatives recommended to our Washington state congressmen and senators that reform begin with comprehensive support for the health of women.

So, when the iceberg is melting, what do we who practice ob gyn do next? Creating a vision of the future is the first step. A mental map of where to invest and move resources is key. Next, inspiring a community of colleagues with a shared vision is critical to moving forward to further steps. Here is where our shared community, through our membership in organizations like ACOG, will be essential.

What to do

I encourage you to participate in advocacy for our profession and our patients. To get started, got to ACOG's government affairs website at

http://www.acog.org/departments/dept_web.cfm?recno=11. It carries plenty of information for getting involved, including ACOG's health reform agenda. While you're there, sign up for ACOG's Inside Scoop. As this issue of Dialogue went to press, Congress still had not acted to prevent the Medicare physician payment cuts. You can urge your congresspeople "to stop the cuts" by calling 1-866-899-4088. □

WSOA Annual Meeting

Continued from page 2

11:40-12:00 WSOA Business Meeting
Noon, Lunch **Geriatric Obstetrics: Issues in the More-or-Less Advanced Maternal Age** Alyssa Stephenson-Famy, MD

1:20-1:40 **Research Talk - Ability**



of Molecular Evaluations of Bacterial Vaginosis in Pregnancy to Predict Preterm Birth Caroline Mitchell, MD

1:40-2:40 **Preterm Birth: Is prevention possible?** Michael Gravett, MD

3:00-4:00 **Evaluation & Management of Fetal Arrhythmia and Congenital Heart Defects** Meg Vernon, MD

4:30 Adjourn.

Thanks much to program chair Dr. Darcy Carr for putting together an outstanding program. □

Room rates for annual meeting

WSOA meeting attendees (Dec. 5-6) can stay at the Fairmont Olympic Hotel, Seattle, for the guaranteed rate of \$235 deluxe king single/double; \$260 executive suite king single/double, plus sales tax. Contact the hotel by Nov. 12 order to ensure accommodations at this rate. Phone (206) 621-1700; fax (206) 621-2271. □

2008 WSOA Officers

President Susan McDonald, MD
Puyallup, (253) 863-6888
mcdonald@soundfamily
medicine.com

President-Elect Robin de Regt, MD
Kirkland/Bellevue, (425)
899-2200, rderegt@
evergreenhealthcare.org

Vice president Andrew Castrodale, MD
Grand Coulee, (509)
633-1911, andyc@
bigdam.net

Secretary/Treasurer Tom Easterling, MD
Seattle, (206) 543-1521
easter@u.washington.edu

Elective Executive Committee

One year Ann Begert, MD, Edmonds
(425) 745-4750,
dra1ann@netscape.net.

Two years Brigit Brock, Seattle,
brigitbrock@mac.com

Three years Rita Hsu, Wenatchee
ritajhsu@msn.com. □