

The Accoucheur

A Newsletter for Primary Care in Childbirth

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Editorial

This second edition of The Accoucheur pays tribute to the 'up and coming' members of the accoucheur community.

Howard Mitnick puts to rest some of the longstanding rumours about the absence of men in maternity care and women's health.

In a section entitled "Fellows - Fab 4", the four most recent graduates from the Maternal Child Health Fellowship at McGill University have each selected articles from the literature that they feel are essential reading for accoucheurs starting a career in maternity care.

Much of the time the focus has been on the demise of maternity care, the lack of resources, and the declining number of providers participating in the birth process. As spring comes and a new cohort will soon join our ranks, it is time to celebrate our colleagues who have chosen to join us in the wonderful experience we have as maternity care providers.



Lisa Graves

Director of Maternal and Child Health Fellowship
Department of Family Medicine, McGill

Support for Breastfeeding...the Male Experience

Yes, I work at the breastfeeding clinic, been doing it for over a year now. Sometimes I forget the anxiety

that comes when they first realize that

the breastfeeding specialist is a man. My anxiety, I mean. Just last week I was reminded of that feeling when a nurse tried to swat me away from a patient. She looked at my co-worker as if she was loco for letting this slovenly, tubby man anywhere near this vulnerable woman's exposed breast. Hold on, now. I'm not going to get all high and mighty on you ... It is strange.

As a medical student I had an entire routine built around the

idea that any doctor who chose to spend too much time puttering around other people's naughty bits was asking for an emotional crisis. Then we had kids and I saw how family medicine obstetrics could be both an emotionally and intellectually satisfying way to shape my practice population and my medical identity.

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Thou Shall Not Eat During Labour... The Debate Continues

Key issue/question

NPO policies were instituted in labour wards in the 1940-50's and have been the standard of practice ever since. Is there sufficient, if any evidence to support this widespread practice?

Evidence

The only existing evidence for NPO policies is based on physiologic principles and studies using surrogate markers for outcome. Conflicting reports exist regarding outcome among women allowed to eat during labour. While some report decreased need for interventions during labour and better Apgar scores among women placed on light diets, others report no difference in outcome.

Summary

In a 1946 landmark paper by Mendelson, gastric aspiration was documented in 66 out of 44,016 pregnancies, and two of these women subsequently died. Following this paper, reports in the UK showed a decline in the incidence of maternal death, which was attributed to NPO policies. NPO policies were soon introduced in much of the Western world. However, introduction of NPO policies have been reported to lead to:

- Increased use of syntocinon
- Increased incidence of instrumental delivery and cesarean section
- Decreased success of VBAC
- Increased NICU admissions.

Bottom line

There may be room for more than ice chips and water in the case room. Even if a light diet were to be allowed during labour, it would likely take many years to document an increase in gastric aspiration as a result. The benefits of increased maternal comfort and decreased ketosis must be weighed against the conflicting reports of benefit and the minimal yet existing risk of aspiration.

Jill Cracower R3

O'Sullivan, G, Scrutton, M. (2003). NPO during labour: is there any scientific validation? *Anesthesiology Clinics of North America*, 21(1): 87-98

Perineal Trauma During Labour: the Good, the Bad and the Ugly

Key Issue

This review article analyzed the numerous interventions recommended to prevent perineal trauma during delivery.

Evidence

The data sources were enormous, and the vast majority of the selected studies were RCTs of techniques affecting perineal trauma.

Summary

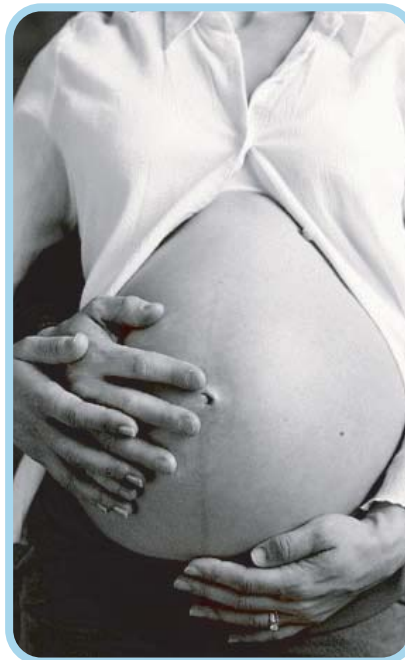
Avoiding episiotomy reduced the risk of sutured perineal trauma by 23% compared to routine use of episiotomy, while liberal use of median or mediolateral episiotomy increased the risk of anal sphincter tears. Median episiotomy caused significantly more third degree tears than mediolateral, but the mediolateral procedure was not protective. Liberal use of episiotomy caused more perineal pain, and did not reduce dysparunia or urinary incontinence. Forceps delivery was associated with far more third degree tears than spontaneous or vacuum delivery. Perineal massage during the weeks prior to delivery resulted in an increase of intact perineums in primiparous women but not multips. Birthing position had no significant difference on perineal trauma outcomes. Comparison of a 'hands-on' approach with mere light support of the infant's head to prevent rapid expulsion revealed no marked difference.

Due to lack of experimental data, no conclusions could be made about a number of interventions, such as specific handling of the perineum, effect of lubricants or hot compresses on perineal trauma, minimizing pushing to slow delivery of the head, delivering with or between contractions, or maneuvers to maintain fetal head flexion.

Bottom Line

Although some reliable observations have been made, there is much room and serious need for further study of the prevention of perineal trauma during childbirth.

Tamara Narine R3



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Eason E, Labrecque, M, Feldman, P. (2000) Preventing perineal trauma during childbirth: a systematic review. *Obstet Gynecol*, 95(3): 464-471

Should Older Women Have Antepartum Testing to Prevent Unexplained Stillbirth?

Key issue

Older women experience higher rates of unexplained stillbirth.

Evidence

Risk of unexplained fetal death has been estimated at 3.6 per 1000 in women >35, (1.1 per 1000 among women under 35), similar to that for women with hypertension and diabetes.

Review of the study

The authors use a decision analysis in a population of older pregnant women from a university hospital database. The strategies were: 1) usual care with no weekly antepartum testing; 2) weekly antepartum testing from 37 weeks gestation and induction if the patient has a positive test; or 3) no antepartum testing but induction at 41 weeks. The object was to estimate the number of additional tests and inductions required to avert each fetal death.

An assumption was made that once a fetus was identified as "at risk", induction would be performed and labour would result in a live birth regardless of delivery method.

Routine antenatal testing could reduce unexplained fetal death from 5.2 per 1000 to 1.3 per 1000 in older women. 863 antepartum tests, 71 inductions, and 14 additional Caesarean deliveries would be required to avert 1 fetal death.

Bottom Line

A large part of the projected benefit of antenatal testing is that non-specific signs of fetal distress would lead to induction at an earlier date, thus limiting the number of older women who are pregnant after 37 weeks and at greater risk for unexplained stillbirth.

Jaqueline Ruttenberg R3

Fretts, RC, Elkin, EB, Myers, ER, Heffner, LJ. (2004) Should older women have antepartum testing to prevent unexplained stillbirth? *Obstetrics & Gynaecology*, 104(1): 56-64



Perineal Repair: Two-Stage Repair Leaving Skin Unsutured vs Three-Stage Repair

Key Issue

Episiotomy repairs can lead to painful intercourse and other issues for post-partum women. Are two-stage or three-stage repairs more effective at reducing these problems?

Evidence

A 2002 Cochrane review indicated that continuous subcuticular repair could be associated with less pain than interrupted closure in the immediate postpartum period. What if we do not need to close the perineal skin edges after having repaired the vaginal and deep perineal tissues?

Review of the Study

Grant et al. conducted a stratified controlled trial to assess two-stage repair with standard three-stage repair. Two-stage repair consisted of repair of the perineal muscle in order to leave the skin edges no more than 0.5 cm apart when the woman was in a lithotomy position and leaving the skin unsutured. These techniques were applied to 1st and 2nd degree tear and episiotomy from spontaneous vaginal delivery or simple instrumental delivery.

At three months follow-up, benefits such as reduced pain and dyspareunia were demonstrated. One year follow-up demonstrated fewer women from the group two-stage repair had the sensation that the area cut or torn during childbirth felt different (described as uneven, smaller, more rigid); 30% vs. 40%, RR=0.75, p <0.01. Other outcomes were similar for both groups (failure to resume pain-free intercourse, persistent perineal pain, resuturing, time needed to resume pain-free intercourse). No apparent disadvantages such as increased breakdown or need of resuturing were observed.

Bottom Line

Two-stage repair seems to have benefits in the short term post-partum period. More serious morbidities (infection, hematoma, fistula) were not assessed. However, the Ipswich study brings us to question these techniques we learn and do routinely.

Linh Le Quoc R3

Grant, A, Gordon, B, Mackrodat, C, Fern, E, Truesdale, A, Ayers, S. (2001) The Ipswich childbirth study: one year follow up of alternative methods used in perineal repair, *British J of Ob and Gyn*, 108(1): 34-40

Upcoming Events



**AAFP Family Centered Maternity Care
Vancouver, BC
July 20-24, 2005**

**UBC 20th Obstetrics update for
Family Physicians
Vancouver, BC
October 20-21, 2005**

**CCFP Family Medicine Forum 2005
Vancouver, BC
December 8-11, 2005**



ALARM COURSES 2005

Quebec QC
June 15-16
(in conjunction with ACM)

Moncton NB
Sept 11-12

Comox-Coutenay Valley, BC
Sept 30-Oct 1

Toronto, ON
Nov 27-28

ALSO COURSES 2005

Vancouver, BC
July 20, 2005

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Through obstetrics, I practice medicine on the family: Follow the woman. Deliver the baby. Follow the baby. Follow the woman post-partum. Follow the partner. But what does this have to do with me being a heavy-set bearded man in a breastfeeding clinic?

I was lucky enough to do a fellowship in maternal-child health at McGill University. While there I trained a half-day a week at the Goldfarb Breastfeeding Clinic. At first I was skeptical. What business did I have mucking around in lactation. My breastfeeding knowledge was scanty at best and I was a man. But here is the punch line. Somehow, my maleness has allowed me to bond to some of the patients differently than my female team mates.

Why? I represent some strange kind of alternate authority in a nearly exclusively female universe. I'm not saying that I deserve that authority but somehow at a basic level the fact that I am a male validating these women's breastfeeding concerns resonates and can break down barriers.

If the woman has a male partner I can model behaviour for them. By extension I can challenge their husband's behaviours and the women don't feel as if it is just some female conspiratorial affair.

What have I learned from the breastfeeding clinic? Most importantly it has helped me find a role in the health care system. Being a new family doctor can be an intimidating enterprise: You know that "jack of all trades, master of none" chestnut?

As well, delivering babies is an art that takes a lot of practice and next to the other superstar accoucheurs in my call group I felt like what I was: a neophyte. However, the breastfeeding clinic gave me the exposure to post-partum women that made me feel as if I could bring something to obstetrics care that might validate the women's trust.

Howard Mitnick
Family Physician, Goldfarb Breastfeeding Clinic

How To Contact Us



Please send your births stories, ideas, feedback, contributions, Conferences etc, to : The Accoucheur at cmnh@cw.bc.ca

The
Accoucheur