Debate Stirs Over Diagnosis, Low Apgar Scores

BY SHERRY BOSCHERT
San Francisco Bureau

CABO SAN LUCAS, MEXICO — Some obstetricians see pediatricians and neonatologists as adversaries when it comes to reducing the risk of a lawsuit after delivering a baby with low Apgar scores.

The alleged problem: Most pediatricians, neonatologists, and pediatric neurologists don’t follow a 2003 monograph produced by the American College of Obstetricians and Gynecologists (ACOG) and the American Academy of Pediatrics (AAP) that sets criteria for declaring that a newborn has hypoxic ischemic encephalopathy (HIE), which is an essential component of cerebral palsy, said O. Richard Depp, M.D., at a conference on obstetrics, gynecology, perinatal medicine, neonatology, and the law.

Until recently, pediatricians and neonatologists who saw a newborn who was not doing well and had depressed Apgar scores simply labeled the problem as HIE. “That is not appropriate,” said Dr. Depp, professor of ob.gyn. at Thomas Jefferson University and Drexel University, Philadelphia.

No one should presume a diagnosis of HIE until other causes have been excluded and criteria for HIE have been met, he said. (See sidebar.) Until other causes have been excluded and criteria for HIE have been met, he said. (See sidebar.)<ref>See pediatricians and neonatologists as adversaries when it comes to reducing the risk of a lawsuit after delivering a baby with low Apgar scores.</ref>

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Dr. Depp said that it’s time for chairs or division chiefs “to sit down and talk about how they will address this problem in a prospective manner.” At Jefferson University, he sat down with the chairpersons of pedi- atrics and anesthesia to negotiate an agreement on the proper use of terms such as HIE and neonatal encephalopathy.

Only recently have physicians attempted to distinguish between neonatal encephalopathy and hypoxic ischemic encephalopathy, he noted. A 1999 international consensus statement, titled, ‘A template for defining a causal relation between acute in- trauma and cerebral palsy’ provided the first clear guidance and was endorsed by 16 medical organi- zations, including ACOG (BMJ 1999;319:1054-9).


Dr. Fanaroff agreed that differentiating hypoxic is- chemic encephalopathy from neonatal encephalopathy is a complex task. “There are a whole lot of things that need to be sorted out. There are some that are acute events, others that are chronic, others that are acute and chronic, and others that are due to genetics or infection,” Dr. Fanaroff said.

“I think we’re all treading on very thin ice, and walking on eggshells’ when labeling problems in a newborn’s chart.

Avoid Mistakes Treating Abdominal Trauma in Pregnancy

BY SHERRY BOSCHERT
San Francisco Bureau

CABO SAN LUCAS, MEXICO — Abdominal trauma during pregnancy endangers the woman and her fetus, but avoiding some common clinical errors in managing such patients can reduce these risks, according to John A. Marx, M.D.

Abdominal trauma occurs in 1%-12% of all pregnancies and leads to hospitalization in 0.4% of such cases, he said at a confer- ence on obstetrics, gynecology, perinatal medicine, neonatology, and the law.

Trauma that causes a pelvic fracture leads to maternal death in 9% of cases and fetal death in 38% of cases. Placental abruption—seen in 2%-4% of women who suffer minor abdominal trauma and half of women with life-threatening ab- dominal trauma—results in fetal death 50%-70% of the time.

Be prepared to recognize shock early and treat it aggressively in pregnant women with abdominal trauma. Don’t rely too much on a nontender ab- domen as a sign that everything is okay af- ter abdominal trauma during pregnancy. Dr. Marx outlined other mistakes to avoid:

- **Failure to teach proper seat belt use.** Motor vehicle accidents cause 70% of all cases of abdominal trauma in pregnancy. Compared with a belted passenger, an un- belted pregnant woman in a car crash has double the risk of vaginal bleeding and quadruple the risk of fetal death.

- **Failure to order needed radiologic studies.** A CT scan of the abdomen delivers 2.6 rads to the fetus, and a CT of the ab- domen and pelvis delivers 3.9 rads, al- though helical CT decreases radiation ex- posure by 14%-30%. “You can still do these studies, but you can’t do a bunch of them,” he said.

- **Failure to obtain coagulation studies.** When disseminated intravascular co- agulation increases during pregnancy.

- **Failure to consider domestic violence.** The woman’s abdomen is the prime site of injury arising from domestic violence. The woman’s abdomen is the prime site of injury arising from domestic violence.

- **Failure to avoid supine hypotensive syndrome.** “This is another oft-missed and easy-to-treat condition,” he said. Tilt- ing the woman’s prone body up and to the left by 15-30 degrees frees the inferior vena cava from pressure from the uterus, which could otherwise cause a significant drop in systolic blood pressure.

- **Failure to perform a perimortem ce- sarean section promptly.** When the woman is dead or moribund but the fetus is viable, performing a C-section within 5 minutes leads to excellent fetal outcomes. Only about 5% of fetuses survive if deliv- ery is delayed at least 15 minutes, and most will have poor neurologic outcomes, Dr. Marx said.

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HIE Criteria Essentials

Four prerequisites must be met in proposing that hypoxic ischemic encephalopathy caused moder- ate to severe neonatal encephalopathy, resulting in cerebral palsy:

1. Fetal umbilical cord arterial blood obtained at delivery with evidence of metabolic acidosis (pH less than 7 and base deficit of 12 mmol/L or more).
2. Early onset of moderate or severe neonatal encephalopathy in infants born at 34 weeks’ gestation or later.
3. Space-occupying lesion—quadriplegic or dyskinetic cerebral palsy.
4. Exclusion of other identifiable causes such as co- agulation disorders, infectious conditions, trauma, or genetic disorders.

The monograph also discusses other criteria that together suggest an intrapartum insult occurred.


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