

Avoid Stitches

Perineal from page 1

The women in the studies practiced digital perineal massage for as little as 4 minutes three to four times per week to as much as 10 minutes daily.

Surprisingly, the women who averaged more than 3.5 massages per week had a significantly longer second stage of labor, compared with those who averaged fewer than 3.5 massages per week, but there was no significant difference in the length of second-stage labor when the women who had episiotomies were excluded. Women with a strong desire for an intact perineum may have been the more frequent massagers, and may have wanted to push longer and avoid episiotomies unless they were truly necessary, the reviewer noted.

An episiotomy can reduce the risk of traumatic tearing during delivery, but most women wish to avoid any types of cuts or stitches with vaginal delivery because of concerns about long-term pain, complications, and decreased sexual satisfaction.

Perineal massage has both medical and midwifery supporters, Dr. Beckmann said

in an interview. "It is now more frequently taught in antenatal classes, and the interest already generated by this review reassures me that many more practitioners are likely to recommend perineal massage to the women they care for."

In the United States, the technique is more often recommended by nurse-midwives than by physicians, although some ob.gyns. do mention it to patients. Anecdotal evidence suggests American women would be amenable to the technique in order to avoid episiotomies and tears.

"I have recommended this technique occasionally," Dr. Robert Marotz, an ob.gyn. in private practice in Chandler, Ariz., and an American College of Obstetricians and Gynecologists' section chair, said in an interview. "Patients who have expressed concerns about avoiding episiotomies and lacerations were receptive to the idea of perineal massage, although I don't have end-result data as to their success with it."

Perineal massage had no significant impact on the incidence of first- or second-degree perineal tears or on third- or fourth-degree perineal trauma, wrote Dr. Beckmann (Cochrane Database Syst. Rev. 2006;doi: 10.1002/14651858.CD005123.pub2). ■

Just a Few Sentences Can Persuade Pregnant Women to Use Seat Belts

KAILUA KONA, HAWAII — Tell pregnant patients to wear seat belts when in a car, and chances are that they'll do it, Dr. William G. Barsan said at a meeting on medical negligence and risk management.

One study found that 92% of mothers who got some prenatal education about seat belt use later reported using seat belts, and 83% could describe proper seat belt placement. Only 71% of mothers who did not get seat-belt advice reported using seat belts, and only 65% could describe proper seat belt placement, said Dr. Barsan, professor and chair of emergency medicine at the University of Michigan, Ann Arbor.

This did not require extensive, 20-minute education sessions but simply telling the patients at an office visit, "The studies are clear—you're better off wearing a seat belt. If you wear it, here's how you want to do it," he added.

There seems to be some confusion among the lay public and even among some clinicians about the benefits of wearing seat belts during pregnancy. Dr. Barsan argued with his own wife about it during her pregnancy, he said at the meeting, sponsored by Boston University.

Modeling studies suggest that the risk of fetal death from a car crash is similar for an improperly restrained woman in a 10-mph crash and a properly restrained woman in a 22-mph crash. "Without wearing a seat belt, it doesn't take much to potentially cause a very bad injury to the fetus," he said.

In another study of pregnant Michigan women in 1993, 32% reported sometimes, rarely, or never wearing seat belts, com-

pared with 23% who said they usually wear seat belts and 45% who reported always wearing them. Those kinds of numbers may help explain results of a 2001 study in Pennsylvania that reported 500 fetal deaths after motor vehicle crashes, compared with 300 deaths of children up to age 4 years who were involved in vehicle crashes in the same time period.

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DR. BARSAN

down on the abdomen and pelvis, Dr. Barsan said. Shoulder belts should be worn off to the side of the uterus, between the breasts and over the mid-portion of the clavicle. There is no evidence to suggest that air bags should be disconnected in vehicles for pregnant drivers or passengers, he added.

"Wearing a seat belt properly can give a lot of protection to the baby," he said.

—Sherry Boschert



"Wearing a seat belt properly can give a lot of protection to the baby."

DRUGS, PREGNANCY, AND LACTATION

GI Agents: Part II

The second part of this three-part series examines the safety of agents used to treat several gastrointestinal diseases that cause significant morbidity in pregnant women.

► **Helicobacter pylori infection:** The bacteria *H. pylori* are associated with chronic active antral gastritis, duodenal ulcer, and gastric ulcer. Although controversial, several studies have associated this infection with severe nausea/vomiting of pregnancy, including hyperemesis gravidarum. Eradication regimens involve dual, triple, or quadruple therapy, typically given for 2 weeks, combining one or two anti-infectives and an antisecretory agent. Bismuth and ranitidine bismuth citrate may be added to the regimen. If clinically acceptable, it is best to delay therapy until after the first trimester. Of the four anti-infectives in these regimens (amoxicillin, clarithromycin, metronidazole, and tetracycline), only tetracycline clearly causes developmental toxicity, but the carcinogenic potential of metronidazole has not been adequately assessed.

Two proton pump inhibitors, lansoprazole (Prevacid) and omeprazole (Prilosec, Zegerid), are the antisecretory agents of choice in *H. pylori* eradication regimens because neither appears to represent a significant risk in pregnancy. Although ranitidine (Zantac) is compatible with pregnancy, both the salt form ranitidine bismuth citrate (Tritec) and bismuth alone are best avoided because the limited human data prevent an accurate assessment of bismuth's risk to the embryo or fetus.

Amoxicillin, clarithromycin, and tetracycline are compatible with breast-feeding. The other agents used for *H. pylori* infection are best avoided in lactation because of potential toxicity to the infant.

► **Cholelithiasis:** Only one gallstone-solubilizing agent, ursodiol (Actigall, Urso), is available in the United States. Reports of exposure to this agent early in pregnancy are limited, but there are more data in the second half of pregnancy, which indicates that the drug does not appear to represent a risk in pregnancy or lactation.

► **Digestive enzymes:** Two digestive pancreatic enzymes—pancreatin and pancrelipase—are used for various conditions that result in deficient pancreatic secretions, such as cystic fibrosis and chronic pancreatitis. These enzymes metabolize fats, proteins, and starches in the duodenum and upper jejunum. Only fragments of pancreatin and pancrelipase are absorbed systemically. Although human data are limited, animal data suggest these enzymes are low risk in pregnancy and lactation. Of note, the enteric coating on many of these products is diethyl phthalate,

and high doses of some phthalates may cause developmental toxicity. However, the very small quantities to which the embryo or fetus may be exposed from the enteric coating suggest that the risk of toxicity is probably negligible.

► **Ulcer prophylaxis:** Sucralfate (Carafate) inhibits pepsin activity and protects against ulceration. Only very small amounts of the drug are absorbed systemically, and it is compatible in both pregnancy and lactation. The prostaglandin misoprostol (Cytotec) is also indicated for ulcer prophylaxis, but this use is contraindicated in pregnancy (see GI Agents: Part I, OB.GYN. NEWS, Nov. 15, 2005, page 9).

► **Flatulence:** Two anti-flatulents available over the counter are the silicone product simethicone and activated charcoal. They also are combined in a single product (Flatulex). Because neither agent is absorbable, they pose no risk to the embryo, fetus, or nursing infant.

► **Obesity:** There is no human pregnancy experience with the lipase inhibitor, orlistat (Xenical). The drug inhibits the absorption of dietary fats. The animal reproduction data and minimal systemic bioavailability suggest that the drug represents a low risk in pregnancy and lactation.

► **Inflammatory bowel disease (IBD):** Mesalamine (5-aminosalicylic acid, 5-ASA) (Asacol, Canasa, Pentasa, Rowasa) is compatible with pregnancy. Reports have described several hundred pregnant women who used the drug without apparent harm to embryo or fetus. Two other agents in this class, balsalazide (Colazal) and olsalazine (Dipentum), are broken down in the colon to 5-ASA. Both seem compatible with pregnancy.

A third agent, sulfasalazine (Azulfidine), is metabolized to 5-ASA plus sulfapyridine. Sulfapyridine readily crosses the placenta to the fetus. When it is used close to delivery, neonatal jaundice and/or kernicterus secondary to displacement of bilirubin from albumin is a theoretical concern but has not been reported. Sulfasalazine appears compatible with pregnancy. All of the IBD agents should be used cautiously during lactation. Close observation of the nursing infant is required if the mother is taking any of these agents.

MR. BRIGGS is a pharmacist clinical specialist, Women's Pavilion, Miller Children's Hospital, Long Beach, Calif., and clinical professor of pharmacy, University of California, San Francisco; and adjunct professor of pharmacy, University of Southern California, Los Angeles. He is also coauthor of the reference book "Drugs in Pregnancy and Lactation."



BY GERALD G. BRIGGS, B.PHARM.