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Delivery room dilemma

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Not long ago, a young woman and her husband came to see me at my office. Thirty-six weeks pregnant, Jennifer had been referred to me by a cardiologist because she had developed a disorder called peripartum cardiomyopathy, which can lead to congestive heart failure.

She already had been hospitalized once, at the beginning of her third trimester. An ultrasound then revealed that her heart was enlarged and severely weakened. Over the intervening months, Jennifer was treated with a cocktail of cardiac medications, and her condition improved. But with her delivery date nearing, the referring physician wanted help in managing her care.

Peripartum cardiomyopathy is relatively rare, estimated to occur no more frequently than 1 in 3,000 in this country. Still, most cardiologists are well aware of it.

After reviewing the reports that had been faxed to my office and obtaining another ultrasound, I sat down with the young couple and discussed my recommendations. I expressed my concern that heart failure could develop quickly if Jennifer went into labor. In my view, the risks to her and her baby were prohibitively high. I recommended an elective Caesarean section.

I didn't tell Jennifer, who was feeling fine, that I was taking care of another woman, not so young, with peripartum cardiomyopathy in the intensive care unit at that very time. Unlike Jennifer, that woman had several risk factors aggravating the disorder, including late maternal age, multiple fetuses (twins) and a history of preeclampsia, involving high blood pressure.

Immediately after her C-section, her lungs rapidly filled with fluid, and she had to be put on a ventilator. Though she was stabilizing, her case had been weighing on my mind.

Jennifer, normally outgoing, with thick brown curly hair and an effervescent smile, became tearful. No one had mentioned a C-section, she said. Was it absolutely necessary?

Looking at her husband, I saw myself only a few months earlier. In August, my wife, Sonia, and I had our first baby. Because of complications during the third trimester, our obstetrician, too, had recommended an elective C- section at 36 weeks.

We also had questioned this recommendation, even the obstetrician's judgment. It seemed excessively cautious to us, both doctors, but she made a convincing case, saying the baby should be delivered under the most controlled circumstances, and we acquiesced. On Aug. 9, we had a healthy baby boy.

Later that afternoon, I spoke with Jennifer's obstetrician. She was not convinced that a C-section was necessary. In fact, she noted, evidence in the obstetrical literature suggested that a vaginal delivery might be safer because it caused fewer alterations in maternal blood flow.

I was aware of some of this data, and I read up on it more after I got off the phone, but it was based on small studies that were not clearly applicable to this case. One problem with clinical research is that the profile of subjects rarely matches that of the patient in front of you.

Though my personal experience probably should not have colored my medical judgment, it undoubtedly did. In the absence of clear-cut evidence, doctors must work in the realm of instinct and faith, and these intangibles necessarily have personal roots.

This sort of situation comes up daily, even in cardiology, the font of evidence-based medicine. It is rare that incontrovertible evidence exists for our medical decisions. So you intuit, make a judgment, and hope that your hunch will serve your patient well.

Later that day, the obstetrician called me back. She had discussed it with her partners. They had decided to go along with my recommendation.

The operating room on the afternoon of the delivery was abuzz: with me were three anesthesiologists, three obstetricians, a pediatrician, a neonatologist, several nurses and nurse practitioners, and Jennifer. She was lying on the table with an epidural catheter, making jokes, as if trying to keep everyone loose.

When she was given a sedative, she said, "When I was growing up, I never did drugs - no pot, not even a cigarette - so this is a real treat for me."

It took about 30 minutes for the anesthetic to reach the level of her belly. An anesthesiologist kept testing her thighs and abdomen with a sharp needle, leaving tiny bleeding marks on her skin. When the anesthetic finally reached the level of her chest, the operation could begin.

I kept staring at the cardiac monitor. The pressure in her heart and lungs remained normal.

Soon, amniotic fluid spilled forth, getting slurped up quickly by a suction catheter. Then, suddenly, the baby was out, tethered by an umbilical cord. A couple of gentle taps and she started wailing, and the room broke into applause.

The baby was placed into the arms of a neonatology fellow and ushered over to a warming table. Someone called out to the father to take a picture, just as someone had called out to me several months earlier. Like my son, Mohan, this baby was beautiful.

When I went back to the cardiac care unit that evening, Jennifer was smiling. "This is the wildest experience of my life," she said. "Thank you."

"But this is the last one," she quickly added. "I can't go through this again."

That was what I would have advised. The consensus is that women with peripartum cardiomyopathy should never get pregnant again.

For part, my intuition had been wrong. The fluid overload that I had predicted had not occurred. I breathed a sigh of relief, and another one the next day when Jennifer went to the postpartum unit to breast-feed her baby girl.

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