With enthusiasm, I began reading the commentary, “A Simple Checklist for Preventing Major Complications Associated With Cesarean Delivery,” by Duff.1 My enthusiasm waned when I read the section “Postoperative Intervention.” The two items listed did not have evidence supporting their inclusion. Duff cites Marik and Plante2 to justify the items’ inclusion; this is a review that cites two other reviews and does not cite any direct references. Marik states that no adequately powered randomized controlled studies have been performed after cesarean delivery. Bates et al3 (cited in Marik) cites small studies demonstrating no efficacy. Bates states, “Given the absence of data... recommendations regarding thromboprophylaxis are by necessity based on extrapolation from other patient populations.”3

These extrapolations may be incorrect. Unfractionated heparin for third trimester thromboprophylaxis4 and for postcesarean thromboprophylaxis5 may be inadequate. To allow neuroaxial anesthesia with cesarean delivery, low molecular weight heparin prophylaxis is started postoperatively. In nonpregnant populations, prophylaxis starts preoperatively because the highest risk is during surgery. The hypercoagulability of pregnancy and fibrinolytic changes with placental detachment may overwhelm any increased fibrinolysis that the intermittent compression may impart.

In closing, I find it ironic that the next commentary in the journal warns of the perils of adopting any strategy without data.6

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REFERENCES

In Reply:
I am very sorry that Dr. Branczio’s enthusiasm waned as he read the final part of my clinical commentary.1 I hope he will agree that the preoperative and intraoperative interventions I recommended are well supported by consistent level I and level II scientific evidence.

I agree that the recommendations regarding prophylaxis for thromboembolism are based on more tenuous level III evidence and extrapolation from clinical studies performed in patients having nonobstetric procedures. He is also quite correct in expressing concern about the possibility of serious neurologic complications in patients who receive low molecular weight heparin in close temporal proximity to neuroaxial anesthesia. This concern makes it potentially dangerous to administer prophylaxis before or during surgery in patients who have received either epidural or spinal anesthesia.

Clearly, we need a large prospective randomized trial to confirm the best approach to prevention of potentially life-threatening thromboembolic events after major obstetric procedures such as cesarean delivery. In the absence of this type of trial, however, I believe that prudence dictates some systematic approach to patients at moderate to high risk for thromboembolism. Pneumatic sequential compression stockings and/or prophylactic doses of either fractionated or unfractionated heparin are the mainstays of such an approach and are endorsed by the Surgical Care Improvement Project. Clearly, the correct dosing and timing of these interventions remain fruitful areas for future research.

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REFERENCE

Does Standardization of Care Through Clinical Guidelines Improve Outcomes and Reduce Medical Liability?

To the Editor:
I read with mixed feelings your article by Kirkpatrick and Burdman.1 As a
The availability and enforcement of standard guidelines has an effect of elevating substandard care, improving outcomes and therefore decreasing litigation. Algorithmic medicine is alluring because it is easy to practice and defend. Yet cookbook medicine doesn’t serve all patients well and challenges our ability to teach residents to think creatively when a patient’s disease isn’t fitting neatly into the flowchart.

American medicine ought to strive for the highest, not the minimal standard. We must provide latitude and protection for those specially experienced to provide significant refinement above the standard of care. We must ensure that research and clinical innovation may still go forward. We must preserve a patient’s right to find and receive reasonable treatment options beyond that in the standard guideline. The example cited on vaginal birth after cesarean delivery (VBAC) is illustrative. Guidelines have brought a reduction in vaginal birth after cesarean delivery (VBAC) patients are not welcome in many practices. Some are driven toward seeking home birth, and others tragically suffer morbidity, loss of fertility, and even mortality from complications of placenta accreta related to repeated cesarean deliveries. Have the guidelines served these women well? It can be too difficult to undo practice once there is a dogmatic standard.

The nature of scientific progress is that new knowledge challenges current practice. We ought to adopt guidelines to assist doctors in making good decisions; however, these guidelines must be deliberate in ensuring latitude for individualized care. Guidelines alone aren’t enough. To really improve outcomes and reduce liability, individual outcomes must be published. Outcomes allow for comparison and self-improvement. Furthermore, the public has a right to these metrics. Those doctors with persistently good outcomes and low complication rates ought to be allowed to practice as they see fit and not be enslaved by a general guideline.

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