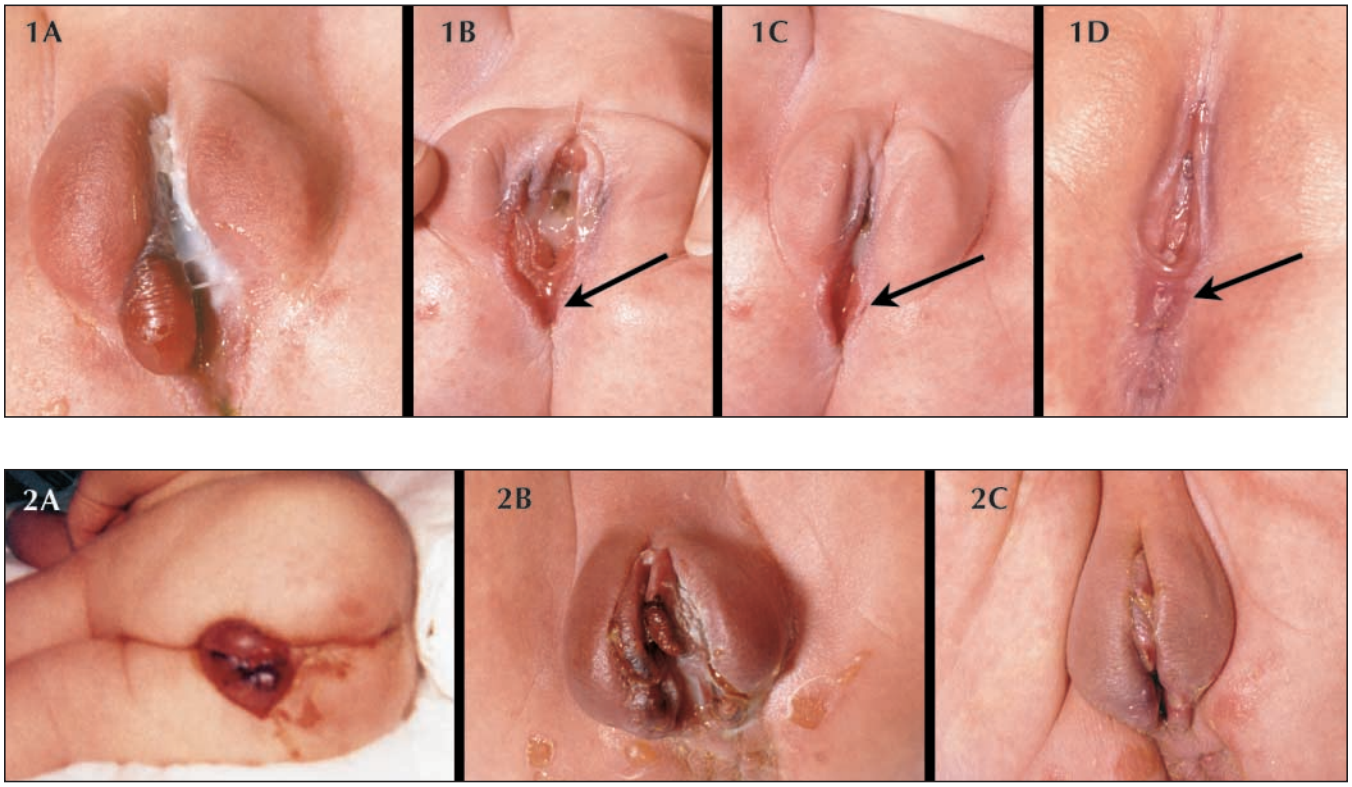
Neonatal genital trauma associated with breech presentation



Courtesy: Dr. Ana Carceller

A female infant was born at 41 weeks' gestation to a 28-year-old primiparous woman after an uneventful pregnancy. The baby was delivered vaginally without instrumentation in a breech presentation 14 hours after spontaneous rupture of the membranes. She weighed 3360 g, was 49.5 cm long and had a head circumference of 36 cm. The only abnormalities on physical examination were diffuse hematomas of the labia majora and an edematous tag originating from the posterior part of the hymeneal ring that had a bluish discoloration (Fig. 1A). Figs. 1B and 1C show the lesions at day 2 and at 1 week. The baby was also seen at 3 months (not shown) and at 1 year (Fig. 1D) without any sequelae related to the birth trauma. A congenital midline fusion of the anogenital area, unrelated to the birth trauma, was also observed (arrows in Figs. 1B, 1C and 1D).

In a similar case a female infant was born at 38 weeks' gestation to a 37-year-old primiparous woman after an uneventful pregnancy. The baby was in breech presentation and was delivered by cesarean section after a 12-hour trial of labour. She weighed 3190 g, was 46 cm long and had a head circumference of 36 cm. The findings at physical examination were unremarkable except for a bilateral hip dislocation and a diffuse hematoma of the labia majora (Fig. 2A). Fig. 2B (day 2) and Fig. 2C (1 week) demonstrate the rapid resolution of these lesions. The baby had orthopedic and physiotherapy follow-up but no further gynecologic sequelae.

Neonatal genital trauma is a recognized but relatively uncommon complication of breech presentations.[1–3] It is more common in babies of primiparous women than in those of multiparous women and can theoretically be prevented by cesarean section without a trial of labour. Diffuse ecchymoses secondary to leakage from capillaries or venules may appear during labour and result in swollen and tender masses with port wine discoloration of the labia majora and labia minora in girls; in boys it results in diffuse hematoma of the scrotum, which has to be differentiated from neonatal testicular torsion. Injury to the abdominal viscera, especially the liver, the spleen or the adrenals, may also occur during a difficult breech presentation and extraction. Hemoperitoneum may also cause a scrotal hematoma in the presence of a patent processus vaginalis.[4]

Infants with neonatal genital trauma may experience mild perineal discomfort and pain on voiding but are otherwise asymptomatic. Jaundice sometimes results from the breakdown and resorption of large hematomas. The appearance of new bruises or petechiae after

the delivery may indicate a bleeding disorder.

A congenital midline fusion anomaly of the genital area is sometimes noted during routine physical examination of young girls. Documentation of such congenital abnormalities in the patient's chart at the time of the newborn examination can help to differentiate them later from other lesions such as those caused by sexual abuse.[5,6]

Perineal lesions usually do not require aggressive treatment. Pressure with a moist saline pack often can control small vulvar hematomas. Analgesics are sometimes required. Topical bacteriostatic and anesthetic ointments are rarely needed.

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Obesity drug sibutramine (Meridia): hypertension and cardiac arrhythmias

Reason for posting: Sibutramine has been taken off the market in Italy after 50 adverse events (primarily tachycardia, hypertension and arrhythmias) and 2 deaths from cardiovascular causes were reported in that country.[1] The European Medicines Evaluation Agency has begun a comprehensive risk-benefit assessment of the drug, which remains on the market in several European countries, including the United Kingdom, where 215 reports of 411 adverse reactions (including 95 serious reactions and 2 deaths) have been reported (Ryan Baker, Health Canada: personal communication 2002), and in France, where 99 adverse events have been reported (including 10 serious adverse events but no deaths).[2] Between February 1998 and September 2001 the US Food and Drug Administration received reports of 397 adverse events, including 143 cardiac arrhythmias and 29 deaths (19 due to cardiovascular causes).[3] Nineteen of the deaths in the United States were from cardiovascular causes; 10 involved people under 50 years of age, and 3 involved women under 30.[3] In Canada reports of 28 adverse events (no deaths) in patients using sibutramine were received between December 2000 and February 2002.

Most of the reported adverse events appear to be known effects (e.g., hypertension, arrhythmias and tachycardia). In Canada, 1 case of chest pain, 1 of stroke and 2 of eye hemorrhage have also been reported. In 3 of the cases reported in Canada, the patient was also taking an antidepressant (a contraindication to sibutramine therapy); however, it is currently unknown whether other patients experiencing adverse events were prescribed sibutramine inappropriately.

The drug: Sibutramine enhances satiety, acting centrally as an inhibitor of both norepinephrine and serotonin reuptake. It is also hypothesized to act peripherally, increasing the metabolic rate, thermogenesis and energy expenditures by