

“WHAT IS THE SIGNIFICANCE OF THE HEAD-TO-BODY DELIVERY INTERVAL IN SHOULDER DYSTOCIA?”

WILLIAM A. GROBMAN, MD, MBA (EXAMINING THE EVIDENCE; DECEMBER 2011)

In shoulder dystocia, 4 minutes is an important cutoff

Although I appreciate Dr. Grobman’s commentary on our article on the relationship between the head-to-body delivery interval in shoulder dystocia and neonatal depression, I am disappointed that he did not address its main point.¹

Dr. Grobman begins his analysis by summarizing the information we present about the relationship between the duration of shoulder dystocia and neonatal depression. He notes one finding of our study—one that is fairly obvious and, as we acknowledged in our study, has been commented on many times before: that there is a correlation between the duration of shoulder dystocia and the extent of neonatal complications.

What Dr. Grobman does not mention, however, is the most significant finding of our study: that, by 4 minutes into a shoulder dystocia, all of the neonates in uncomplicated cases of shoulder dystocia had been born. It is this finding, with its implications for the timing and intensity of delivery efforts during shoulder dystocia, that is new and previously unpublished.

Instead of discussing this new observation, Dr. Grobman writes at some length about the concepts of selection bias and ascertainment bias. These concepts may have been relevant if the main finding of our article had centered on the difference between control and case groups. However, our main finding in no way involved a comparison between the two groups.

Dr. Grobman’s commentary may



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be interesting from the point of view of how one should statistically analyze a study, but he overlooks what is most important in our article and applies his statistical analysis in a way that is irrelevant to our article’s most important conclusion.

Henry Lerner, MD
Newton, Mass

Reference

1. Lerner H, Durlaccher K, Smith S, Hamilton E. Relationship between head to body delivery interval in shoulder dystocia and neonatal depression. *Obstet Gynecol.* 2011;118(2 Pt 1):318-322.

» Dr. Grobman responds
Issues regarding types of bias are indeed relevant

I appreciate Dr. Lerner’s comments, although I disagree with his sentiment. I chose to discuss issues of ascertainment and selection bias because Dr. Lerner and colleagues presented two different groups, and seemed, from comments in the article, to glean conclusions from the comparison of these groups. In such an instance, issues regarding types of bias are indeed relevant in terms of understanding the validity of the conclusions. Dr. Lerner’s response continues to emphasize the importance of a

comparison group. He notes that, “by 4 minutes into a shoulder dystocia, all of the neonates in uncomplicated cases of shoulder dystocia had been born.” This only provides insight if one also knows that there was a complicated group in which this was not the case. For example, if complicated cases also were likely to be delivered by 4 minutes, the “significance” of the finding in uncomplicated cases may not be so significant at all. Therefore, I continue to believe that the issues I raised regarding the construction and comparison of the two groups are not only relevant, but seminal to interpretation of the conclusions.

“HOW TO REPAIR BLADDER INJURY AT THE TIME OF CESAREAN DELIVERY”

ROBERT L. BARBIERI, MD
(EDITORIAL; DECEMBER 2011)

Running suture at the bladder dome may be problematic

As usual, I enjoyed Dr. Barbieri’s editorial. I have a nit to pick, however.

In surgical step 2, Dr. Barbieri recommends the use of running sutures and two-layer closure. When Dr. Alan Perlmutter was the urologic consultant at the old Free Hospital in Boston, a number of “successful” bladder repairs were performed by the ObGyn staff, leaving the patients with symptomatic scarring in the bladder dome secondary to the bunching and puckering that running suture produces in that anatomic site.

Dr. Perlmutter’s teaching point: The repaired bladder dome must be as flexible and expansive as it was before the cystotomy. To this end, he recommended a single, full-thickness layer of neat, interrupted 3-0 plain suture to oppose the edges of the incision. I have used this



technique ever since without any complications.

Robert L. Shirley, MD
Winchester, Mass

Methylene blue may be better than sterile milk to assess the bladder

I enjoyed Dr. Barbieri's editorial, but I would recommend that the surgeon forget the sterile milk and use, instead, 100 cc of normal saline with 10 cc of methylene blue, filling the bladder retrograde to ensure that there are no other leaks. I leave a catheter in place for 2 weeks and give prophylactic antibiotics.

Vincent Culotta, MD
New Orleans, La

More tips for repair of bladder injury

A 5-cm laceration at the dome of the bladder allows visualization of the ureteral openings to ensure that two-layer closure with absorbable suture can be performed safely. I also leave a Foley catheter in place for 7 days, with computed tomography or magnetic resonance imaging generally unnecessary before removal.

Robert F. Porges, MD
New York, NY

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How to secure payment for bladder repair

When inadvertent injury to the bladder occurs during cesarean delivery, additional payment for the repair may be forthcoming if the repair is correctly coded and billed. The repair would be considered a multiple procedure during the operative session, and reimbursement would be at a reduced rate, based on intra-operative work only (usually 50% of the allowable for the additional code reported).

If cystorrhaphy is required, you have two codes from which to select:

51860 Cystorrhaphy, suture of bladder wound, injury or rupture; simple (22.39 RVUs)

51865 Cystorrhaphy, suture of bladder wound, injury or rupture; complicated (27.10 RVUs)

In most cases, the repair will involve simple suturing; therefore, CPT code **51860** will be the procedure most frequently reported. The linking diagnosis for this procedure code is **998.2**, *Accidental puncture or laceration during a procedure*.

The basic rule in coding is to list the code with the highest value first on the claim to ensure that it is paid at 100% of the allowable. In this case, the codes available to report a cesarean delivery (**59510–59515** and **59618–59622**) all have a higher RVU than the simple bladder repair code **51860**. Therefore, correct billing would be:

59510 (linked to an ICD9 code that specifies the reason for the cesarean, such as 649.81 [Onset (spontaneous) of labor after 37 completed weeks of gestation but before 39 completed weeks of gestation, with delivery by (planned) cesarean section; delivered, with or without mention of antepartum condition] or 654.21

(Previous cesarean delivery; delivered, with or without mention of antepartum condition)

51860–51 (linked to code 998.2)

Note that payment for bladder repair may also be forthcoming if the laceration occurs during any other type of surgery, and the coding format would be the same for the repair. However, Medicare will not reimburse the surgeon who caused an iatrogenic injury to repair it during the surgical session at which it occurred.

Melanie Witt, RN, CPC, COBGC, MA
Independent Coding and Documentation
Consultant

Former Program Manager
Department of Coding and Nomenclature
American Congress of Obstetricians and
Gynecologists
Washington, DC

>> Dr. Barbieri responds

Suggestions are appreciated

On behalf of the readers of OBG MANAGEMENT, I thank Dr. Shirley, Dr. Culotta, and Dr. Porges for their expert clinical suggestions.

Dr. Shirley points out that it is important not to bunch and pucker the bladder repair, and interrupted sutures would reduce the risk of this problem.

I agree with Dr. Culotta's suggestion to use methylene blue (or indigo carmine) to assess bladder integrity. Because methylene blue can cause pelvic tissues to maintain a bluish hue for a considerable period of time, some surgeons prefer to avoid it. Indigo carmine is less likely to produce this effect.

Dr. Porges observes that a cystotomy is helpful because it allows the surgeon to directly assess the integrity of the trigone. Far from posing a "problem," a cystotomy in the dome of the bladder actually creates an advantage, permitting more complete assessment of urinary tract integrity.

I appreciate Ms. Witt's advice on procedure coding for cystotomy repair.