Acute otitis media after forceps delivery

While running an ambulatory paediatric clinic, the mother of a crying baby wondered whether forceps delivered babies were more prone to otitis than other babies. To our knowledge, this association has not been reported. But, on the other hand, facial nerve injury is more common among those delivered by forceps; it is caused by compression of diploic bone of the mastoid process where the facial nerve is located superficially.2 It is clear that this kind of extraction applies some pressure over the ear of the baby. The head vulnerability is well known: long term consequences have been recognised after mild head corner.2

To estimate the differences of proportion of acute otitis media (AOM) between children delivered by forceps and other babies we conducted an electronic medical records review of all singleton children attending a primary care paediatric clinic, born full term from 1 January 1996 to 31 December 2004. Table 1 shows the characteristics of the children. Sex was comparable, birth weight of non-operative vaginal delivery babies (NO) was lower, vacuum assisted babies (VA) were older at AOM diagnosis, and rates of neonatal admission were not comparable.

AOM was diagnosed by a history of acute onset of signs and symptoms and otoscopic examination of the eardrum.1 Of 1449 deliveries, there were: 754 NO, 217 F, 52 VA, and 426 CS (caesarean sections). AOM had been recorded in 234 (31.0%) of children born by NO, 87 (40.0%) of F, 13 (28.8%) of VA, and 124 (29.1%) of CS.

The analysis showed that forceps delivered babies were associated with an increase in proportion of AOM (odds ratio (OR) 1.48; 95% confidence intervals (CI) 1.08 to 2.03; p = 0.015) compared with NO.

There were no differences in AOM proportions between VA and NO (OR 0.85; 95% CI 0.46 to 1.58; p > 0.3). There were no differences in AOM proportions between CS and NO (OR 0.91; 95% CI 0.70 to 1.18; p = 0.3).

Our finding could be confirmed or discarded by ongoing longitudinal studies. If it is confirmed, it will strengthen the resolve to pay careful attention to the comments of our patients. It is already known that VA is at least as safe as forceps for the mother and the neonate. Long term consequences of operative vaginal delivery need to be explored: a prospective study should be undertaken to find if this association really exists.

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References

Table 1 Patient characteristics

<table>
<thead>
<tr>
<th>Feature</th>
<th>Non-operative delivery (n = 754)</th>
<th>Forceps delivery (n = 217)</th>
<th>Vacuum delivery (n = 52)</th>
<th>Caesarean section (n = 426)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Birth weight mean (SD)</td>
<td>3315.2 (400.7)*</td>
<td>3429.3 (388.2)</td>
<td>3496.2 (416.7)</td>
<td>3383.4 (467.8)</td>
</tr>
<tr>
<td>Ratio</td>
<td>1.08</td>
<td>1.18</td>
<td>1.42</td>
<td>1.34</td>
</tr>
<tr>
<td>Female</td>
<td>25 (3.1)*</td>
<td>11 (5.0)*</td>
<td>8 (15.5)*</td>
<td>25 (5.8)*</td>
</tr>
<tr>
<td>Newborns admitted to special care (%)</td>
<td>18.2 (12.9)</td>
<td>17.4 (10.8)</td>
<td>23.7 (12.6)*</td>
<td>18.9 (13.0)</td>
</tr>
<tr>
<td>Age, months, at AOM diagnosis mean (SD)</td>
<td>18.2 (12.9)</td>
<td>17.4 (10.8)</td>
<td>23.7 (12.6)*</td>
<td>18.9 (13.0)</td>
</tr>
</tbody>
</table>

*p<0.05.
These factors are also related to educational position, and neighbourhood deprivation, such as birth weight, parental socioeconomic achievement. In contrast, its contribution to a conceptual model would be preceding educational inequalities in health, and to provide more guidance to study to contribute to the debate on the link between early cognitive ability to later health outcomes and that inclusion of education of daughters. This suggestion is not much more recent. Men's exposure to radiofrequency radiation has reportedly been linked to a lowered testosterone/gonadotrophin frequency. Radiation has been reported that both exposed men and exposed women tend to produce significant excesses of reduced testosterone levels in rats. And I have therefore been reported that offspring sex ratio of people were exposed to electromagnetic fields, the ratio remained unchanged, compared with their expected value of 0.515 to 0.465. Then, to stand 8 chances in 10 of offspring sex ratio of exposed and non-exposed pregnancies, the ratio of offspring sex ratio at birth is partially controlled by parental hormone levels at the time of conception. I thank Dr James for his letter. He may well have been correct for the citations of the related studies and also the estimation of the sample size. However, I wish to make some comments. Not only in my report, but also in other reports the sample size was much lower than that estimated by James. Among published data, the article of Guberman et al was based on 1781 births (508 were from exposed and unexposed pregnancies, respectively), which is a comparatively large sample size and it is near to the required sample size, calculated by James. Guberman et al found that there was no statistically significant difference between exposed and unexposed pregnancies for offspring sex ratio. Irgens et al reported that offspring sex ratio of exposed women in industry exposed to electromagnetic fields was significantly reduced; while in men exposed to the fields the ratio did not show significant difference. On the other hand, experimental design studies showed that when rodents (mice and rats) were exposed to electromagnetic fields, the offspring sex ratio significantly increased or remained unchanged, compared with their expected value. These studies, although not unanimous, cumulatively suggest that both exposed men and exposed women tend to produce significant excesses of reduced testosterone levels in rats. And I have therefore been reported that offspring sex ratio of people were exposed to electromagnetic fields, the ratio remained unchanged, compared with their expected value of 0.515 to 0.465. Then, to stand 8 chances in 10 of offspring sex ratio of exposed and non-exposed pregnancies, the ratio of offspring sex ratio at birth is partially controlled by parental hormone levels at the time of conception. I thank Dr James for his letter. He may well have been correct for the citations of the related studies and also the estimation of the sample size. However, I wish to make some comments. Not only in my report, but also in other reports the sample size was much lower than that estimated by James. Among published data, the article of Guberman et al was based on 1781 births (508 were from exposed and unexposed pregnancies, respectively), which is a comparatively large sample size and it is near to the required sample size, calculated by James. Guberman et al found that there was no statistically significant difference between exposed and unexposed pregnancies for offspring sex ratio. Irgens et al reported that offspring sex ratio of exposed women in industry exposed to electromagnetic fields was significantly reduced; while in men exposed to the fields the ratio did not show significant difference. On the other hand, experimental design studies showed that when rodents (mice and rats) were exposed to electromagnetic fields, the offspring sex ratio significantly increased or remained unchanged, compared with their expected value of 0.515 to 0.465. Then, to stand 8 chances in 10 of offspring sex ratio of exposed and non-exposed pregnancies, the ratio of offspring sex ratio at birth is partially controlled by parental hormone levels at the time of conception.
controls. Taken together it seems that the published data are not sufficient to conclude that the offspring sex ratio tends to produce significant excesses of daughters when parents are exposed to electromagnetic fields.

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References

Public health policy

“Advancing the public’s health has always been the stated goal of healthy policy, even if in practice a systematic bias in favour of responding to ill health and tackling disease has remained all pervasive and remarkably impervious to change”.

While this quote doesn’t appear until halfway through Public Health Policy, it is from this perspective that Hunter approaches his analysis. The text details the history of the public health sector in the United Kingdom as well as the problems and issues that have faced and will continue to face the policy makers who enjoy responsibility for the public’s health, from the House of Commons to the NHS. While historically confining his analysis to the UK, the well organised history of the struggles faced in the UK parallel those faced by developed and developing countries. The pitfalls of the competing priorities of the “downstream” focus on current health care offerings (treatment) compared with the “upstream” positive effects of shifting focus to a public health perspective (prevention) are analysed on many levels and from varying viewpoints.

Hunter offers potential solutions to some of the difficulties that face decision makers struggling to formulate health policy that reflects a shift in priorities. The book is well written and offers insights useful for all who have an interest in improving the public’s health, whether in the UK or elsewhere.

S Goldie

Ethics for health care, 2nd edition

Oxford University Press has recently published a second edition of this popular and widely read primer on medical ethics. Designed as a teaching tool for a broad range of health care professionals, the text draws upon a series of contemporary problems as the author illustrates the key features of ethical thinking.

The chapters are designed in a sequential rather than encyclopaedic fashion, developing themes through a series of over 50 suggested tasks for the reader to engage in before moving further. Almost half of these individual and group exercises incorporating tutorial/problem based triggers are new to this edition, reflecting the author’s emphasis on helping the reader understand the material by placing it within their own context.

Subsequent text then explores the issues, guiding the reader on the process of analysing everyday health care issues in an ethical framework, while focusing on the health care worker to client interaction.

Although many examples considered in the text are drawn from contemporary Australian sources, they are presented in an inclusive fashion for an international readership. In particular, the author considers the cultural, religious, and sociological contexts that inform ethical considerations, rather than limiting herself to any one theoretical framework.

In summary, this book provides an excellent programme of instruction for health care workers in applying ethical reasoning to the problems they encounter in everyday practice, leaving the reader with workable tools they can use on a daily basis.

S Margolis