are equally fraught with methodologic challenges, especially observation bias.

David R. Little, MD, MS
Wright State University
Dayton, Ohio

References

1. Little DR, Mann BL, Godbout DF. How family physicians distinguish acute sinusitis from upper respiratory tract infection: a retrospective analysis. J Am Board Fam Pract 2000;13:101–6.
2. Diagnosis and treatment of acute bacterial rhinosinusitis. Summary evidence report/technology assessment: no. 9. Rockville, Md: Agency for Health Care Policy and Research, 1999.
3. Smuchy JJ, Becker LA, Glazier RH, McIssac W. Are antibiotics effective treatment of acute bronchitis? A meta-analysis. J Fam Pract 1998;47:453–60.
4. Little DR, Mann BL, Sherk KW. Factors influencing the clinical diagnosis of sinusitis. J Fam Pract 1998;46:147–52.

Uterine Inversion

To the Editor: I am writing regarding your recently published article "Uterine Inversion: a Life-Threatening Obstetric Emergency."[1] Drs. Hostetler and Bosworth state that "the most likely cause [of uterine inversion] is strong traction on the umbilical cord . . . during the third stage of labor." This statement is referenced to information from the 20th edition of *Williams Obstetrics.* The authors of this text do not reference where this opinion came from. In June 1995 *Obstetrics and Gynecology Clinics of North America* published an article by Wendel and Cox[2] on the management of uterine inversions. In their article they reference work by Schaefer and Veprosvsky from 1949 that included mismanagement of the third stage of labor as the cause of uterine inversion; then they go on to reference multiple studies that have disproved this theory. They state:

> Modern reports, however, fail to show a direct association of inversion with mismanagement of the third stage of labor. In fact, 15% to 50% of inversions occur "spontaneously" after the third stage of labor. These recent findings suggest a congenital predisposition to inversion as a consequence of abnormalities of uterine musculature or innervation. Further supporting evidence for this theory is that the condition occasionally recurs in subsequent labors.

As textbooks often lag behind other bodies of knowledge, I think this might help clarify the medical myth that cord traction is the usual cause of uterine inversion.

Miles Rudd, Md
Warm Springs, Ore

References

1. Hostetler DR, Bosworth MF. Uterine inversion: a life-threatening obstetric emergency. J Am Board Fam Pract 2000;13:120–3.
2. Wendel PJ, Cox SM. Emergent obstetric management of uterine inversion. Obstet Gynecol Clin North Am 1995; 22;261–73.

Birth and Death: Through a Child's Eyes

To the Editor: Dr. Feldman's response[1] to my concerns about her advocating sibling presence at childbirth is even more worrying than her original article.[2] Several of the studies she cites in support of her position do not in fact do so: one study[3] does not deal with this subject at all. At least one other[4] is not a scientific study but is the memoir of a sibling birth attendance written by members of a family in a rather self-justifying manner. Furthermore, several of the studies have serious methodological problems in that they use psychological instruments that were created ad hoc and not subjected to reliability and validity analyses, so that their usefulness in assessing the psychological impact of birth attendance on children remains to be shown.[5] On the other hand, some of the articles Dr. Feldman cites illustrate very clearly the concerns expressed in my letter. A vivid description of the impact on children viewing the birth of a sibling is provided by Daniels[6(p20)]:

> There were very few cases without some expression of negative feelings (5 of 30); fear was the predominant negative emotion. The children who had the hardest times were probably those who perceived their mothers as helpless, in pain or out of control. One child thought her mother might die if the placenta did not come out. In one case, there was a hemorrhage that quickly responded to bimanual compression. The child was so nauseated that he had to leave. . . . In several cases, the mother's crying out persisted as a troublesome memory. A 5-year-old said to me, "Well, you see, there's crying. I am used to crying . . . but screaming . . . ." During delivery she had buried her face in the support person's shoulder.

Another author[7(p16)] cited by Dr. Feldman cautions: "there are several reasons to be cautious about extrapolating from (her own) findings:

3. The negative observations bade of *some* children by the midwives suggest the need for an independent observational study of child behaviors at birth.
4. The follow-up was short-term only" (emphasis in original)

Short-term, methodologically flawed studies should not decide this issue. Furthermore, the responses quoted from the children themselves graphically show the traumatic potential of attendance at sibling birth. It should be noted that these reactions occurred even though these children were prepared by a special program for children scheduled to witness sibling birth. Dr. Feldman claims that with preparation there is no danger to children in observing sibling birth.

Daniels[6(p21)] comments further:

> The children's learning (about birth) validates one of the many reasons parents give for wanting their children with them. . . . It is reasonable to speculate that some of the confusion and anger of their own childhood lies behind this parental determination. . . . *Furthermore, it is the parents, in the last analysis, who will be the ones to help their children integrate and recover from whatever traumatic effects may have occurred, whatever emotional price children may pay for the learning* (emphasis supplied).

This indifference to the possibility of physician-assisted traumatogenesis in children is extraordinary and dismaying. Daniels' speculations about her parents' motivations make good psychological sense. They raise the question as to whether we, as professionals, should participate in parents' well-intentioned but misguided efforts to compensate for their own psychic traumata in childhood by subjecting their own children to psychological insult. Would we recommend a child be sutured without anesthesia because a parent thought it would build character or constitute a useful learning experience?

The difficulty with this philosophy is that neither Dr. Feldman nor the references she cites take any account of the internal psychic lives of the children concerned in which fantasy plays an extremely important role.[8] We have known for decades that trauma is not caused by the mere occurrence of an external event, but that the meaning of that event to the person is crucial.[9,10] This is a general phenomenon in children: children frequently blame themselves for the failure of their divorcing parents' marriage or for the death of a parent or sibling despite reassurances and factual evidence to the contrary. Some children have extended nightmares after viewing movies such as the *Wizard of Oz*, despite reassurances from loving, concerned parents.

Piaget[11] has shown that the cognitive and emotional capacities of young children are too immature to appreciate and understand the events they witness, and the younger they are, the more likely fantasy rather than reality testing will dominate the interpretation of an intensely charged emotional event. This is why mere explanation and reassurance given to a child in preparing for a sibling birth will not guarantee protection from trauma. Moreover, recent evidence suggests that childhood trauma can *after only a single exposure* cause functional brain damage[12] in addition to psychological consequences. For those readers who are interested in understanding more about the internal psychic lives of children, I would recommend the Fraiberg[13] book in the reference list below.

Notwithstanding the above, I can do no more than to re-invoke Dr. Feldman's own comments on this subject: "I can draw no definite conclusions about the impact of these experiences on Hanna's psyche or her own future life choices." The point of my letter was to plead for a consideration of the child's psychological vulnerabilities in recommending attendance at sibling birth. We cannot predict in advance which child will suffer untoward sequelae from such an experience.

Because this is the case, as Dr. Feldman's own words attest, we should follow a longstanding ethical tradition in medicine: *primum non nocere.*

Merton A. Shill, PhD
Wayne State University Medical School
Detroit

References

1. Feldman E. Birth and death through a child's eyes. J Am Board Fam Pract 2000;13:87–8.
2. Feldman E. Birth and death: through a child's eyes. J Am Board Fam Pract 1999;12:344–4
3. MacLaughlin SM, Johnston KB. The preparation of young children for the birth of a sibling. J Nurse Midwifery 1984;29:371–6.
4. Hathaway J, Hathaway M, Hathaway O, et al. Children at birth. Sherman Oaks, Calif: Academy Publications, 1978.
5. Nunnally JC, Bernstein IH. Psychometric theory. New York: McGraw-Hill, 1994.
6. Daniels MB. The birth experience for the sibling: description and evaluation of a program. J Nurse Midwifery 1983; 28:15–22.
7. Lumley J. Preschool siblings at birth: short-term effects. Birth 1983;10:11–6.
8. Sarnoff CA. Latency. New York: Jason Aronson, 1976.
9. Krystal H, Krystal JH. Integration and self-healing: affect, trauma and alexithymia. Hillsdale, NJ: Analytic Press, 1988.
10. Tuch RH. The construction, reconstruction, and deconstruction of memory in the light of social cognition. J Am Psychoanal Assoc 1999;47:153–86.
11. Flavell JH. The developmental psychology of Jean Piaget. Princeton, NJ: Van Nostrand, 1963.
12. Markowitsch J, Kessler J, Van Der Ven C, Weber-Luxenburger G, Albers M, Heiss WD. Psychic trauma causing grossly reduced brain metabolism and cognitive deterioration. Neuropsychologia 1998;36:77–82.
13. Frailberg SH. The magic years. New York: Simon & Schuster Trade, 1996.

Management of Nondeflating Urethral Catheter

To the Editor: Regarding your article in the March-April issue of the *JABFP* on managing the urethral catheter (Shapiro AJ, Soderdahl DW, Stack RS, North JH Jr. Managing the nondeflating urethral catheter. J Am Board Fam Pract 2000;13:116–9), when I looked at the algorithm diagram, it all seemed logical until I got to where it shows chemical rupture involving ether, chloroform, acetone, of mineral oil. Reading through the article further, I noted that one paragraph states that "[s]everal chemicals have been used to dissolve the balloon wall and thereby allow its deflation. Ether, chloroform, acetone, and mineral oil are among the agents most commonly used. Unfortunately, exposure of the bladder urothelium to these chemicals can result in chemical cystitis, bladder contractures, hematuria, bladder rupture, and death. In addition, balloon fragments might be retained within the bladder, predisposing the patient to a variety of complications . . . . " I could never imagine instilling ace-