Correspondence

We will try to publish authors' responses in the same edition with readers' comments. Time constraints might prevent this in some cases. The problem is compounded in a bimonthly journal where continuity of comment and redress are difficult to achieve. When the redress appears 2 months after the comment, 4 months will have passed since the original article was published. Therefore, we would suggest to our readers that their correspondence about published papers be submitted as soon as possible after the article appears.

Nutritional Supplements

To the Editor: The article by Eliason et al[1] on the use of dietary supplements, while interesting, confirmed the data from numerous other studies.[2-10] It is an area that could benefit from further investigation but should be approached in an unbiased scientific manner. I have the following concerns about the article:

1. For a scientific paper the authors show a clear bias with statements such as "manufacturers are free in this context to make unsubstantiated claims...."
2. I question how the authors can recruit 200 consecutive patients in a busy office and have no one refuse to participate or slip past the research assistant.
3. Simply telling physicians they should talk to their patients about nutritional supplements without providing a structure to that discussion is not helpful to the physician or patient.[11]

I am pleased that their practice has a better understanding of their population's supplement use and would encourage the authors to look deeper and more objectively into this interesting issue.

Herbert L. Muncie, Jr., MD
University of Maryland
Baltimore, Md

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Early Newborn Discharge

To the Editor: Dr. Eric Wall's editorial on early newborn discharge was a remarkably balanced contribution to the often emotional debate on this topic.[1] I would like to add a clarification to his unreferenced statement defining early newborn discharge as a hospital stay of 24 hours or less after an uncomplicated vaginal delivery. As Dr. Wall notes, studies of early discharge have been limited by, among other problems, inconsistent definitions of early discharge. He fails to point out, however, that the American Academy of Pediatrics (AAP) and the American College of Obstetrics and Gynecology (ACOG) clearly define "early" and "very early" discharge as stays of 48 and 24 hours or less, respectively, after uncomplicated vaginal delivery.[2] In addition, the AAP's recent refinement of its recommendations states that the conditions that need to be met before discharge are unlikely to be fulfilled in less than 48 hours. It also states it is essential that infants discharged in less than 48 hours be examined by experienced health care providers within 48 hours of discharge.[3]

I am concerned that Dr. Wall's definition of early discharge implies that the discharge of infants at 25 to 47 hours of age is routine, therefore requiring only routine follow-up. Your readers should be aware that AAP strongly disagrees.

Diane J. Madlon-Kay, MD
St. Paul Ramsey Medical Center
St. Paul, Minn

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2. Guidelines for perinatal care. 3rd ed. Elk Grove Village, Ill: American Academy of Pediatrics and American College of Obstetricians and Gynecologists, 1992.
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The above letter was referred to the author of the article in question, who offers the following reply.

To the Editor: Dr. Madlon-Kay raises an important issue regarding the definitions of "early" and "very early" newborn discharges that I neglected to mention in my

editorial. I would still make the case, however, that the appropriate follow-up of newborn infants discharged within 24 hours or between 25 and 48 hours has yet to be based upon scientific evidence. Whether the American Academy of Pediatrics agrees or disagrees should not be the deciding factor for the discriminating physician. Rather, this discussion should persuade family physician researchers that this issue needs more rigorous investigation.

Eric M. Wall, MD, MPH
QualMed Oregon Health Plan, Inc
Portland, Ore

In Utero Exposure to Medroxyprogesterone

To the Editor: In their case report, Drs. Brady and Brundage[1] omit some of the essential information required for reflections on assessment and management of the patient described. After the initial injection, was this patient advised to use backup contraceptive methods for 1 month? The description of the return visit of this patient for a second medroxyprogesterone injection does not mention several vital points. Had the patient's menses been regular or irregular? Had her menses been absent?

Before giving a repeat injection of the contraceptive, many clinicians would have a low threshold for doing a pregnancy test to rule out a preexisting pregnancy.[2] This is all the more important because amenorrhea and irregular bleeding are common side effects of this contraceptive method. In the case described, the patient appears to have conceived approximately 6 to 8 weeks after the initial injection. She would most likely have been amenorrheic for 6 weeks when she came in for the second injection. Because rates of amenorrhea rise with continued use,[3] the early onset of amenorrhea in this patient should have prompted pregnancy testing before the second injection was given.

Furthermore, the distinction needs to be made between different causes of in utero exposure to medroxyprogesterone. Both of these causes appeared in the case described. One reason for in utero exposure is contraceptive failure, a pregnancy occurring after the injection is given. The second reason is giving an injection to an already pregnant patient. The first scenario is potentially less serious, because contraceptive failure is most likely due to a failure to maintain adequate levels of circulating progesterone. Inadequate levels could be related to inadequate depth of injection or rubbing of the injection site, causing premature release of the depot.[4] In this scenario in utero exposure is less likely.

If the patient is already pregnant when the injection is given, however, there is a greater potential for in utero exposure. Fortunately, ruling out a pre-existing pregnancy with a pregnancy test prior to injection in patients who return with a history of irregular bleeding or absent menses can prevent in utero exposure in most cases. Pregnancy testing is especially important for patients starting with this form of contraception who do not yet have the protective benefit of cumulative overlapping doses of medroxyprogesterone.

L. C. Coutts
Baylor College of Medicine
Houston, Texas

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