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.

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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.

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