the People's Doctor
A MEDICAL NEWSLETTER FOR CONSUMERS by Robert S. Mendelsohn, MD

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IN THIS ISSUE:

Conception, Pregnancy and Problems during Pregnancy

The first Newsletter I ever wrote was on the subject of Pregnancy and Childbirth. Quite a few of my subsequent Newsletters have touched on the subject of pregnancy, but in this one, I examine for the first time questions of conception and problems which may result from pregnancy.

Dr. Robert Mendelsohn

Planning a pregnancy

Q My fiance and I are planning to have a baby soon, and I'm wondering what my chances are of becoming pregnant for a February baby. I've had two abortions, one in May 1973 and the second in April 1975, and I've read that chances of having a successful pregnancy are not good with this kind of history. My fiance says I shouldn't worry about getting pregnant. I've been off birth-control pills for six years. How should I achieve a successful pregnancy?--L.M.

A Get married. You should enter into a contract between the two of you before you contract for a new life.

After you take this first step, consider such additional factors as the timing of sexual intercourse to coincide with the time of ovulation. Maintain an excellent diet, do proper exercise, and get plenty of sleep.

A previous abortion does markedly increase the chance of temporary and sometimes permanent sterility. Yet I consider my first response the most important for you. Get married. The cultural and biological advantages of the legal, societal and religious bonds of marriage are, in my opinion, a crucial component in overcoming sterility.

Q I am a 35-year-old mother of two children aged two and four. My husband and I would like to have another child, but my age is of some concern to us. My two pregnancies were normal, and I delivered two normal and healthy babies.

Can I hope to have another healthy baby at my age? So much is being said about this question in the media that I really hesitate to have another child. Can you give us the latest statistics regarding the percentage of healthy children born to women 35 and over?--J.D.

Pregnancy after 35

For more than a decade, doctors have been warning older women about the dangers of having abnormal babies. But just because a half-truth gets repeated over and over, that doesn't make it a truth. There is no question that some statistics show an increased incidence of Down's Syndrome (mongolism) in babies born to women whom doctors call "geriatric mothers." On the other hand, there are statistics that show that this risk is limited to women who, throughout their lives, have had lots and lots of X-rays, both medical and dental.

Conflicting statistics cannot serve as a firm standard that will help you or anyone else reach a decision. Nor can your doctor's views be completely trusted. In recent years, doctors have developed a tendency to lump together increasing numbers of pregnant women as "high risk." Thus, doctors warn against teen-age pregnancies, while at the same time lowering the desirable age limit at the upper end. Before long, if you don't have a baby between 24 and 24 1/2 years of age, you will have missed the boat. If you and your husband have this powerful urge to have another child, talk to women who have had babies when they were your age or older. Read such books as Gail Brewer's "Pregnancy after Thirty" (Random House). Or, if you are part of the Judeo-Christian tradition, you may recall that the very first Commandment reads, "Be fruitful and multiply." There is no modifying clause that reads "between ages 20 and 30."

Q

I would like some assurance that I can no longer get pregnant. I am 53 years old, and my last menstrual period occurred four years ago. My youngest child is 22 years old. I've been leery of relaxing during intercourse for fear of pregnancy, even after all these years.--Mrs. S.G.

Fear of Pregnancy at 53

An international authority in the field of fertility, Melvin Cohen, M.D., who is professor of obstetrics and gynecology at Northwestern University, tells me that as a rule of thumb, menopausal women who have not menstruated for one year are "safe" from becoming pregnant. Dr. Cohen says he has not witnessed an exception to this rule in his several decades of wide experience with a very large clientele.

I hope that this answer allays your fears, but if not, I think you should look for deeper reasons to explain your continuing anxiety. There could be another reason why, after four years of no menstrual periods, you still are concerned about pregnancy.

Test tube babies

The births of test-tube babies, like every such scientific breakthrough, answers some questions, but at the same time raises even more questions. I would like to share with you some of my concerns which I hope will be addressed in the future.

The first test-tube baby was of low birthweight and was delivered prematurely because the mother showed some signs of toxemia. There are two major theories on the cause of toxemia of pregnancy. One widely held theory is that nobody knows the cause. The other, advanced by such doctors as Tom Brewer, M.D. ("What Every Pregnant Woman Should Know," Random House, $8.95), points the finger at improper maternal nutrition, restriction of weight gain during pregnancy, and the prescribing of diuretics and other medication during pregnancy. Therefore, the following questions must be raised: What was the mother's diet? How much weight did she gain during her pregnancy? What medications did she take?

The reason for undertaking this technique was to bypass the blocked fallopian tubes. According to a Chicago-area obstetrician, William Matviuw, M.D., major causes of blocked fallopian tubes include previous abortions, gonorrhea and other venereal diseases, the intrauterine device (IUD), and the very tests used by doctors in determining tubal

patency (openness). These tests, which introduce air or an oily substance into the tubes, may also introduce bacteria which lead to inflammation and subsequent obstruction.

Obviously, if we can prevent blocked tubes, there will be little need for controversial technology to bypass the effects.

The ethical issue presents an excellent opportunity for in-depth discussions of the positions of different religious systems. To Jews, this first case did not pose difficult ethical decisions, since the husband was the sperm donor and since Jewish law generally provides no objection to collection of the husband's semen for this purpose.

Obviously, other religions have different attitudes. Now is the time for full and open discussions that can provide guidelines for future cases which may not be as clearcut. Like many other modern breakthroughs, from moonshots to transsexual surgery to heart transplants, the test-tube babies again raise the eternal question "Should it be done just because it can be done?"

My husband and I have a two-year-old daughter, and we are thinking seriously of having another child. However, several years before my first pregnancy, I had an upper and lower G.I. series of X-rays. When my daughter was about a year old, I had another lower G.I. as well as an entire body scan during which I was injected with a radioactive substance. The tests were negative--no tumors, just very persistent colitis.

I have read that the reproductive organs are very prone to damage from radiation. My first pregnancy and delivery went extremely well, and our daughter is beautiful and healthy, but all the X-ray exposure I've been subjected to concerns me. If a woman is born with a lifetime supply of eggs, what are the possible effects of so much radiation on her eggs?--K.B.

X-rays and pregnancy

Speaking as a physician, I recommend you contact all the doctors who have X-rayed you in the past and find out, as accurately as possible, the total amount of radiation you have received throughout the years. Then, consult John Gofman's landmark publication "Radiation and Human Health" to help you quantitatively determine your risk of having a malformed child. Next, consult nutritional authorities, including those versed in macrobiotics, who claim that their approach can cancel out the deleterious effects of radiation.

Now, speaking as one human being to another, in spite of all the damaging X-rays you have received, I nevertheless encourage you to have more children. Admittedly, this is not a medically-based opinion, but rather an opinion based on the fundamental Old Testament teaching that is shared by most of Western civilization.

Having given you advice as one person to another, let me hastily scramble back into my medical role to warn you that, with your next pregnancy/pregnancies you should stay away from X-rays, diagnostic ultrasound, doctor-prescribed medication, and every other form of dangerous obstetrical intervention.

I look forward to receiving a birth announcement from you introducing your next beautiful and healthy child.

Routine pregnancy screening

The dangers presented to pregnant women by hospital procedures has motivated some hospitals to require pregnancy testing on all women of childbearing age. According to Medical Trial Technique Quarterly, a survey of 236 hospitals revealed that four percent of them routinely

screened for pregnancy. One 300-bed New Jersey hospital, which has no obstetric department, routinely performed pregnancy tests on all women aged 12 to 50. Of 4,111 women tested on admission, 111 were found to be pregnant. Of these, only 69 (59 percent) knew they were pregnant and had so informed the hospital personnel and/or physicians. At one leading medical center, the director of nuclear medicine requires pregnancy testing for women who are undergoing radioisotope testing. Eleven of 230 women so tested had not known they were pregnant. Based on these figures, as many as 115,000 of the 8 million women hospitalized annually for non-obstetrical reasons may have unrecognized pregnancies.

Harold L. Hirsh, M.D., J.D., concludes: "It is essential for the physician to order a pregnancy test when X-rays, narcotics and psychotropic drugs, general anesthesia or other contraindicated therapeutic or diagnostic procedures are prescribed. Otherwise, a vulnerable women is not tested, delivers a deformed baby, and inevitably sues the health care providers."

Internal exams may rupture membranes

Another example of how doctors can endanger the birth process appears in the medical journal Obstetrics and Gynecology, January 1984. Dr. John P. Lenihan, Jr., M.D., of the Department of Ob/Gyn, U.S. Air Force Hospital, Royal Air Force, Lakenheat, U.K., discloses that the examining hand of the doctor is a major cause of premature rupture of membranes or PROM (too early breaking of the bag of waters). This common complication of pregnancy subjects the mother and fetus to the risk of both illness and death from infection (chorioamnionitis). The routine internal examinations carried out by many obstetricians open up a pathway for bacteria to enter the cervix and produce infection and ruptured membranes.

In Dr. Lenihan's study, the incidence of Caesarean sections was more than twice as high in women with PROM as in those whose membranes remained intact. In 175 patients in whom no pelvic examinations were performed until term, the incidence of PROM was six percent, but in 174 patients in whom pelvic examinations were performed weekly (after the 37th week), the incidence was 18 percent. Therefore, if you are a pregnant women, when the obstetrician tells you he wants to perform a pelvic examination to determine the condition of the cervix and other organs, ask him whether he is aware of the published hazards of this kind of examination.

Can you please settle an argument between me and a friend? He says he knows a woman who carried a baby full-term in her fallopian tube; the baby supposedly was born in a New Orleans hospital in 1962 or 1963, and both mother and baby survived. I say it's impossible to carry a baby to term in a fallopian tube. Could such a pregnancy occur?--E.A.

Ectopic pregnancy

There are reports, admittedly rare, in medical journals, of tubal (or ectopic - which means out of place) pregnancies in which the baby, obviously delivered through an abdominal incision, survived. To my knowledge, every one of these cases came as a surprise to the doctor. Doctors are trained to diagnose ectopic pregnancies as early as possible (in the first several weeks of pregnancy) and to operate immediately, removing the pregnancy, usually the entire tube, and sometimes the ovary.

Until about three years ago, I accepted this conventional teaching without question. But then, one of my medical students challenged my equanimity by posing the following hypothetical case: A woman had salpingitis (inflammation of the tube) from an IUD. She was operated on, the surgeon removing the tube and ovary on one side. He told her there was some indication of involvement of the other side, but not enough to

remove that tube and ovary as well. She later became pregnant, and, as is fairly common in women who have had salpingitis (also known as pelvic inflammatory disease), the infection had left her remaining tube partially scarred. Thus, the fertilized egg left the ovary, but because of the deformed tube which resulted from the scarring, was unable to successfully negotiate this passageway into the uterus where normal development could have occurred. Instead, she developed a tubal pregnancy. When the doctor made the diagnosis, there was no immediate emergency, but he nevertheless advised surgery.

The hypothetical woman posed the hypothetical question: "Doctor, if you carry out your plans, I may never be able to have a baby. I live five minutes away from your hospital, and I am willing to take the risk of a sudden hemorrhage and rupture (which I understand could result in my death) because I have an overwhelming desire to have my own child, even though the risks are high and my chances are admittedly small. However, it seems to me that the decision, doctor, should be mine and not yours. Besides, doctor, how do you doctors know what my chances are under careful medical observation? How many cases have you personally observed without immediately operating? Do you have any up-to-date statistics or are you depending on half-century-old anecdotal information?

Three years after that medical student raised this question, I still have no answers. I wonder if there is a physician willing to accept this kind of challenge. I wonder whether there are women who feel this way. My only conclusion is that a combination of inquiring readers and inquisitive medical students guarantees me plenty of food for thought.

Our daughter, who is approximately three-and-a-half months pregnant, recently contracted chickenpox from her young school-age niece. When she asked her obstetrician whether this disease might affect the fetus the way German measles does, he was unable to answer her question, simply stating that he didn't know.

We are hoping you can give us a positive answer. Does our daughter have to worry about any possible aftereffect on the baby because of exposure to this disease?--Mr. and Mrs. C.W.

Can chickenpox harm fetus?

What I learned (and what your daughter's obstetrician certainly should have learned) in medical school still holds true--namely that chickenpox in a pregnant woman results in either a miscarriage or else a perfectly normal baby. This is an entirely different situation than German measles which, presumably due to its mild nature, may cripple the fetus without destroying it.

I nevertheless would warn pregnant women about the danger, not from chickenpox itself, but rather from some of the medicines doctors prescribe in its management which certainly may affect the fetus.

Risks from aspirin

Recent studies (as reported in the New England Journal of Medicine, October 1982) have shown that when aspirin is given to women late in pregnancy, it can cause bleeding tendencies in their babies, including hemorrhages under the skin, bleeding into the whites of the eyes, bloody urine, and hemorrhage after circumcision. Bleeding under the scalp of newborns, known medically as "cephalhematoma," has been shown to be associated with maternal aspirin intake. In addition, the mothers themselves may experience abnormal hemorrhaging after delivery as well as excessive bleeding during Caesarean section.

As many as 69 percent of all pregnant women take aspirin during the last trimester of pregnancy. To compound the problem, more than

100 over-the-counter drugs contain aspirin.

This state of affairs leads me to make the following suggestions:

1) If you or your newborn baby have suffered the kind of abnormal bleeding described above, ask your doctor if any of the drugs which you bought over-the-counter or which he prescribed for you contained aspirin.

2) If you are pregnant, write down a list of all drugs in your medicine cabinet, and ask your doctor to tell you which ones contain aspirin.

3) If your doctor has failed to warn you against taking aspirin during your prenatal visits, ask him to explain this important omission.

Adolescent pregnancy

After years of warnings from doctors and social workers about the risks of adolescent pregnancy, a study from Mount Sinai Medical Center in Chicago shows that adolescence does not increase the risks of complications to mother and fetus. In a recent Journal of the National Medical Association, Dr. Pedro A. Poma reported on 130 pregnant adolescents aged 13 to 16 and 150 women aged 20 to 37. Dr. Poma's findings showed that adolescents did not experience greater difficulty in pregnancy, labor, delivery or postpartum than the older women studied.

Bendectine ingredient contained in Unisom

Some interesting information about the drug Unisom, Pfizer's trade name for doxylamine, has caught my attention because doxylamine is one of the two (the other is Vitamin B6 or pyridoxine) elements which make up Bendectin, the anti-nauseant recently removed from the market by its manufacturer. (Bendectin was implicated in the causation of birth defects.)

Unisom is prescribed as a treatment for insomnia; Pfizer says the patient will fall asleep faster and wake up less often during the night after taking Unisom. The prescribing information does say that the drug should not be taken by pregnant women. Yet, as the source who passed along this information points out, what if a woman takes this drug because of sleep difficulties, and her insomnia turns out to be caused by a pregnancy she was unaware of at the time? One of Unisom's side effects is impotence, so my source poses two questions: "What if this drug affects the fetus through the father-to-be? What if the father-to-be is unable to father because he took this drug?"

Furthermore, each Unisom tablet, which is available without prescription, contains 25 mg doxylamine. Yet the dosage of this drug in Bendectin (which did require a prescription) was only 10 mg. Thus, Unisom contains two-and-a-half times more doxylamine than Bendectin did, yet it can be purchased over the counter. And that's true not only of the Pfizer product. Doxylamine also is contained in Decapryn (a non-prescription drug for allergies), and it recently has been approved by the FDA for inclusion in a possible new form of Sominex (another non-prescription sleep aid).

Potpourri

Accutane users should not give blood

I repeatedly have warned you of the dangers of blood transfusions, and I have recommended that, if your doctor orders a transfusion for you, you should ask him two questions:

Whose blood am I getting? A paid donor (who may carry hepatitis) or a voluntary donor?

What is the lifestyle of the donor? Gay (more likely to carry the agent that transmits AIDS) or otherwise?

Now, a third very important question must be added: What prescribed medications was the donor taking?

The reason you must ask the third question is because the FDA recently sounded an alert to blood banks not to accept blood for transfusion from

persons who are being treated with Accutane, the new drug for severe acne. The FDA warned that if such a donor gives blood, and if that blood is transfused into a patient who is pregnant or soon becomes pregnant, there may be a risk of the fetus suffering severe birth defects.

What do we learn from this startling new warning?

1) Let us hope that all blood banks are asking this question.

2) Let us pray that all donors, who have many incentives for giving blood, will answer truthfully.

3) In the absence of an emergency, every woman of childbearing age should be required to show a negative pregnancy test before being given a non-emergency blood transfusion.

4) Every parent of a child who has a severe birth defect should carefully review the mother's history to see if she received a blood transfusion shortly before or during her pregnancy.

5) Since Accutane is far from the only drug known to cause birth defects, blood banks should begin at once to ask every donor what drugs (both prescription and over-the-counter) they are taking. Furthermore, since the FDA advises that people on Accutane should not give blood for a month after the end of their treatment, blood banks should be asking prospective donors about drugs which they took in the past.

6) Since blood banks are unlikely to ask all the tough questions that might eliminate many donors, and since plenty of donors are unlikely to knock themselves out of the box by giving totally truthful answers, I repeat my time-tested recommendation--if your doctor tells you you need a blood transfusion, try to pass as a Jehovah's Witness.

Medical News

If you suffered from an uncomplicated heart attack 30 years ago, the doctor was likely to instruct you to get into bed--your own bed at home. He then would make house calls to monitor and treat you. Today, paramedics rush you to the hospital, where you are placed in an intensive care unit in which you are wired up, intubated, fed intravenously, etc. Which treatment is better? Have we really come a long way, baby?

Not according to the Journal of the American Medical Association (January 20, 1984). In its "Commentary" section, a dozen studies are cited which compare home vs. hospital care of myocardial infarction (heart attacks). We are told, "The fact remains that presently available studies comparing home and ward care with CCU (Coronary Care Unit) care do not demonstrate that outcomes are substantially influenced by admission and care in a CCU."

The authors of this commentary, two distinguished physicians from the University of Washington School of Medicine, Seattle, conclude: "Our current strategy of forcing all patients into some kind of high-technology expensive care is hardly defensible."

Since it may be too late to discuss the question of home vs. hospital treatment of heart attacks when your doctor makes that diagnosis, now, before that eventuality, ask him whether he has read this JAMA article.

Dr. Mendelsohn's latest book, "How to Raise a Healthy Child in Spite of Your Doctor," has just been published by Contemporary Books ($13.95).

"MalePractice: How Doctors Manipulate Woman," Dr. Mendelsohn's last book, is now available in paperback from Contemporary Books ($6.95).

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Another View

by Marian Tompson
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As I spoke with some women who had switched from being cared for by a physician with their first pregnancy to being cared for by a midwife with their second, it quickly became clear that an inability to communicate was one of their main sources of discontent. "I always felt like I was keeping him from his other patients and seldom got the information I needed," said Kay. "Once, I actually had to refuse to leave the examining room until he gave me a straight answer." Sherrie's woman obstetrician "was very businesslike, and I felt awkward trying to talk with her. She didn't sit and talk. She would examine me and was out the door." Joy's doctor was part of a group practice, and this meant that Joy could not be sure which of four doctors actually would attend her during labor. "It was important to me to get to know the attendant I would be working with, but I was never given time to get to know any of the doctors very well, nor did they seem to think it was important that they get to know me."

All three women recognized the importance of working with an attendant who had the necessary skills and with whom they felt comfortable. (Joy's litmus paper test was based on whether the attendant sat down to talk or stood near the door.) The midwives they finally chose were women they felt really cared about them, whose interest extended beyond their physical symptoms, and whom they came to look upon as friends and part of the family.

This supportive rapport may not only facilitate a woman's ability to give birth naturally and safely by her own efforts, but also has an effect that goes beyond the delivery. In a 1979 study of the emotional effects of childbearing on women, Mehl and Peterson confirmed a relationship between a woman's ability to actively participate in her childbirth experience and the gains she made in personal self-confidence and overall mental health as a result of her birthing experience. We can assume that this enhancement also improves her relationship with her baby.

"As women, we are responsible for whom we bring into our lives and into our birthing rooms," writes Claudia Panuthos ("Transformation Through Birth, A Woman's Guide," Bergin & Garvey, $12.95). "Hopefully our choice will honor and respect our birthing process and our human dignity. When we give to our physicians omnipotent power we invite them to control our births and to rescue (as well as persecute) us as the victims."

Panuthos recognizes that today's childbearing woman "attempts to give birth in a political atmosphere of conflict, confusion and change." As modern-day obstetrical practices are challenged, she also becomes increasingly pressured (both externally and internally) to birth correctly and even perfectly.

A good place to start looking for the right attendant is in the latest edition of NAPSAC's Directory of Alternative Birth Services. (Send $5.95 to NAPSAC, P.O.Box 428, Marble Hill, MO 63764.) Along with the names and addresses of 4,500 midwives, childbirth centers, non-interventive physicians and childbirth educators, the directory contains an excellent consumer's guide with questions parents can ask to evaluate the competence and desirability of attendants, hospitals or home birth services. Midwifery is an attitude, not a list of credentials. As Joy discovered during her search, "There are doctors who practice midwifery and some midwives who practice obstetrics, and you can't assume anything until you've met the practitioner."