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# Current Resources for Evidence-Based Practice, May 2020

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## ABSTRACT

An extensive review of new resources to support the provision of evidence-based care for women and infants. The current column includes a discussion of a new National Academy of Medicine report on planned place of birth and implications during the SARS-CoV-2 pandemic and commentaries on reviews focused on anorectal sexually transmitted infections and feeding methods following cleft lip repair in infants.

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## Place of Birth During a Pandemic

In February 2020, the National Academy of Medicine (formerly the Institute of Medicine) released a consensus report entitled, “Birth Settings in America: Outcomes, Quality, Access, and Choice” ([National Academies of Sciences, Engineering, and Medicine, 2020](#)). The take home messages from this report are that (a) planned community and planned hospital births can be safe depending on pregnancy characteristics; provider experience; and easy, seamless availability of higher-level care should it be required; (b) no birth location is risk-free; and (c) any effort to increase maternal choice around birth place in the United States must explicitly consider and address the pervasive racial and ethnic disparities experienced by women of color in the current maternity care system.

As a long-time community birth researcher, I eagerly anticipated the publication of this report. As soon as it was released, I spent the next several evenings poring over the document, reading related literature on ethics and choice, and planning this May 2020 column. I had a pretty solid outline for a column in which I would have delved into the global safety literature and then explored the idea of informed consent in maternity care. I would have explored the idea of choice and what it means in terms of planned place of birth, specifically within our unique, U.S. health care system.

That was almost exactly one month ago. My, how times have changed.

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I sit here now on March 19, and nothing is the same. By the time you read this column in another 6 weeks, I cannot begin to speculate about what our lives will look like—what your lives, as health care providers, will look like. (Thank you, so much, for doing what you do.) As an epidemiologist, I have spent the past two weeks answering questions from my friends and family; no doubt this will continue as we are bombarded by daily news—some true, much of it not—about the novel coronavirus. My children are out of school at least through the end of April, and my university has announced that all classes for spring quarter will be held online only. Hopefully these and other social distancing measures will allow our health care system to keep up with the sudden increased demand for critical care. Perhaps by early May, when this is published, we will be beginning to return to our normal lives. As I write, China is just beginning to relax some of their mandatory social isolation measures following several days of no observed community-transmitted cases. Hopefully, this is where the United States will be in 6 weeks. Although, of course, it is entirely possible that China will be forced to return to mandatory social distancing in the meantime and that we would be wise to follow suit.

Given this global pandemic backdrop, the question of planned community birth suddenly becomes much more salient. Thus far, it seems that pregnant women and children are not at high risk of severe disease given SARS-CoV-2 infection (so few data are available that I cannot provide citations). However, like so many other things

about our current situation, we just don't yet know. What we do know is that even under best case scenarios, in the next few weeks our hospitals will likely exceed their capacities, and our health care workforce will shrink as physicians and nurses become infected themselves. Hopefully, the excess demand is not too high. Regardless, as a pregnant woman, would you want to have your baby in a hospital in which most other patients have COVID-19? In which the medical staff are stretched even more thin than normal? In which there might not even be a bed for you? Unfortunately, most women who are due to give birth in the next several weeks will not have a choice.

Perhaps it is time that we as a nation embrace the idea of planned community birth. This change cannot happen overnight. We currently do not have nearly enough midwives, most U.S. women are not socialized to accept community birth as a viable option, most midwives are not comfortable with community birth, and most local health care systems are not set up to allow seamless transfer of care when indicated. But imagine if our maternity care system looked more like the one in the Netherlands, where planned home birth is considered a viable option for most women, midwives are comfortable in both settings, and transfers into and out of obstetric care when indicated are seamless (Amelink-Verburg & Buitendijk, 2010). Surge capacity in the midst of greatly increased demand secondary to a pandemic would still be an issue, but I cannot help but think that maternal and child outcomes over the next several weeks would be better if women in labor were able to safely stay away from our overwhelmed hospitals.

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## From Cochrane Database of Systematic Reviews (CDSR) Issues 1–2 (2020)

### Systematic Reviews in CDSR: Women's Health

- Exercise therapies for preventing or treating aromatase inhibitor-induced musculoskeletal symptoms in early breast cancer
- Hormone replacement therapy after surgery for epithelial ovarian cancer
- Laparoscopic ovarian drilling for ovulation induction in women with anovulatory polycystic ovary syndrome
- Rapid point of care test for detecting urogenital Chlamydia trachomatis infection in nonpregnant women and men at reproductive age
- Traditional suburethral sling operations for urinary incontinence in women

### Systematic Reviews in CDSR: Fertility, Contraception, and ART

- Regular (ICSI) versus ultra-high magnification (IMSI) sperm selection for assisted reproduction

### Systematic Reviews in CDSR: Pregnancy and Birth

- Acupuncture or acupressure for pain management during labour
- Membrane sweeping for induction of labour

### Systematic Reviews in CDSR: Infant Health and Breastfeeding

- Early versus late erythropoietin for preventing red blood cell transfusion in preterm and/or low birth weight infants
- Ibuprofen for the prevention of patent ductus arteriosus in preterm and/or low birth weight infants
- Ibuprofen for the treatment of patent ductus arteriosus in preterm or low birth weight (or both) infants
- Intravenous immunoglobulin for preventing infection in preterm and/or low birth weight infants
- Intravenous immunoglobulin for suspected or proven infection in neonates
- Late erythropoiesis-stimulating agents to prevent red blood cell transfusion in preterm or low birth weight infants

- Paracetamol (acetaminophen) for patent ductus arteriosus in preterm or low birth weight infants
- Paracetamol (acetaminophen) for prevention or treatment of pain in newborns
- Sound reduction management in the neonatal intensive care unit for preterm or very low birth weight infants
- Surfactant for pulmonary haemorrhage in neonates. Early erythropoiesis-stimulating agents in preterm or low birth weight infants

## Evidence-Based Reviews From Other Sources

### Recent Evidence-Based Reviews: Women's Health

Adunlin, G., Cyrus, J. W., Asare, M., & Sabik, L. M. (2019). Barriers and facilitators to breast and cervical cancer screening among immigrants in the United States. *Journal of Immigrant and Minority Health*, 21(3), 606–658. <https://doi.org/10.1007/s10903-018-0794-6>

Aleixo, G. F., Fonseca, M. C. M., Bortolini, M. A. T., Brito, L. G. O., & Castro, R. A. (2019). Pelvic floor symptoms 5 to 14 years after total versus subtotal hysterectomy for benign conditions: A systematic review and meta-analysis. *International Urogynecology Journal*, 30(2), 181–191. <https://doi.org/10.1007/s00192-018-3811-3>

Arabin, B., Timmesfeld, N., Noever, K., Behnam, S., Ellermann, C., & Jenny, M. A. (2019). How to improve health literacy to reduce short- and long-term consequences of maternal obesity? *Journal of Maternal-Fetal & Neonatal Medicine*, 32(17), 2935–2942. <https://doi.org/10.1080/14767058.2018.1450383>

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**Featured Review:** Lau, A., Kong, F. Y. S., Huston, W., Chow, E. P. F., Fairley, C. K., & Hocking, J. S. (2019). Factors associated with anorectal chlamydia trachomatis or neisseria gonorrhoeae test positivity in women: A systematic review and

meta-analysis. *Sexually Transmitted Infections*, 95(5), 361–367. <https://doi.org/10.1136/sextrans-2018-053950>

In this meta-analysis, Lau et al. (2019) explored factors that might conceivably be associated with anorectal infections with chlamydia or gonorrhea in women: concurrent urogenital infection, concurrent oropharyngeal infection, and anal intercourse. As expected, more women overall had *C. trachomatis* infections than *N. gonorrhoea* infections; however, as all studies were conducted at sexually transmitted infection clinics, the prevalences of both were quite high in the study populations.

In 13 studies on concurrent urogenital and anorectal tests, the prevalence ratio (proportion of dually positive women to urogenital negative/anorectal-positive women) was 32.2 (95% confidence interval [CI], 25.6, 40.7) for *C. trachomatis* infections and 89.3 (53.1, 150.3) for *N. gonorrhoea* infections. In five studies on concurrent oropharyngeal and anorectal tests, the prevalence ratios were 8.8 (6.8, 11.5) for chlamydia and 34.8 (10.2, 118.2) for gonorrhea. Finally, in two studies on associations between anal intercourse and anorectal infections, the prevalence ratio was 1.0 (0.7, 1.4) for chlamydia and 4.3 (2.2, 8.6) for gonorrhea. The authors concluded, “anorectal NG [*N. gonorrhoea*] was substantially more associated with urogenital and oropharyngeal detection than was anorectal CT [*C. trachomatis*]. Furthermore, anorectal NG was associated with anal intercourse, but anorectal CT was not” (Lau et al., 2019, p. 365).

**Comment:** The mechanism for anorectal infections via anal intercourse is obvious, but it is interesting that anal intercourse seems to lead to positive tests for anorectal gonorrhea but not anorectal chlamydia. Less obvious are the potential mechanisms for anorectal infection with either of these organisms in women who deny anal intercourse. Lau et al. (2019) speculated that urogenital infections may be transmitted to anorectal infections via toileting and that oropharyngeal infections may be transmitted to anorectal infections via the gastrointestinal tract. Regardless of mechanism, these co-infections are more common among women with gonorrhea than women with chlamydia.

Given that the symptoms for these two infections are very similar, the take home message for women's health nurses is to swab all sites—urogenital, anorectal, and oropharyngeal—when testing for these

two sexually transmitted infections, regardless of the woman's self-reported sexual history. Particularly in women who deny recent anal intercourse, this will likely require careful education and shared decision-making.

### Recent Evidence-Based Reviews: Fertility, Contraception, and ART

- Abarbanell, G., Tepper, N. K., & Farr, S. L. (2019). Safety of contraceptive use among women with congenital heart disease: A systematic review. *Congenital Heart Disease*, 14(3), 331–340. <https://doi.org/10.1111/chd.12752>
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### Recent Evidence-Based Reviews: Pregnancy and Birth

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**Featured review:** Matsunaka, E., Ueki, S., & Makimoto, K. (2019). Impact of breastfeeding and/or bottle-feeding on surgical wound dehiscence after cleft lip repair in infants: A systematic review. *Journal of Cranio-Maxillo-Facial Surgery*, 47(4), 570–577. <https://doi.org/10.1016/j.jcms.2019.01.019>

Cheiloplasty, or cleft lip repair surgery, most usually occurs around 3 months of age, well after feeding methods have been established (Matsunaka et al., 2019). During the post-operative period, parents are often advised to feed the infant with a spoon or cup out of fear that the suction required to breast- or bottle-feed would interfere with wound healing. In this systematic review, the authors explored whether that advice is necessary.

The review included five studies: three randomized, controlled trials and two cohort studies. The combined sample size across all included studies was 342 infants. Overall, four wound dehiscence events were recorded: three in cup/spoon feeding groups (two were thought to be secondary to falls rather than feeding) and one for which the feeding group was not noted, but the authors in the original study claimed that the dehiscence was unrelated to feeding method (Matsunaka et al., 2019). In two of the included studies, secondary outcomes related to weight gain were reported. In both cases, the breast- or bottle-feeding group fared better. Matsunaka et al. (2019) found no reason not to continue with the established feeding method, whether breast- or bottle-feeding, for infants undergoing cheiloplasty.

**Comment:** Unfortunately, this body of evidence is too small, and the studies included in this review have too many methodologic flaws for evidence-based conclusions to be drawn. The expected incidence of wound dehiscence following cheiloplasty is 1.3% (Kantar et al., 2018); thus among 342 surgeries we would

expect four events, exactly as observed. However, four events across four studies have very little statistical power. The fact that no dehiscence events were observed in the breast- or bottle-feeding groups is somewhat comforting, but because the sample sizes were so small, we cannot say with any degree of confidence that such events would not be observed given a larger study sample.

Because this surgery usually occurs when infants are 3–6 months old, they have well-established feeding routines. It is easy to imagine a scenario in which cheiloplasty followed by surgeon-recommended spoon or cup feeding leads to early weaning, particularly in settings in which women do not have access to high-quality breast pumps. The literature summarized by Matsunaka et al. (2019) does not allow us to draw definitive conclusions about preferred feeding method following cleft lip repair, at least in terms of wound healing. However, this also means that cup or spoon feeding has not been shown to be beneficial. Until such time as larger, more definitive studies are conducted, it seems that the known benefits of avoiding early weaning likely outweigh the unproven claims of increased wound dehiscence if breastfeeding continues.

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