1. Do you routinely dictate an operative note for operative vaginal deliveries? If so, what details of the delivery are essential to include in the note?

Response from Dr. Edward R. Yeomans:

I do not routinely dictate an operative note for operative vaginal deliveries. A good handwritten note should suffice. For either type of note, the following details are important to include:

- Indication for operative vaginal delivery
- Station and position of the fetal head prior to starting the procedure
- A qualitative description of traction used
- Type of instrument
- Classification of the delivery according to the ACOG guidelines
- Type of anesthesia
- Site of delivery (OR, labor room)
- Type of episiotomy (if performed)
- Birth weight
- Apgar scores
- Cord gas results (if obtained)
- Any maternal or neonatal complications

If shoulder dystocia is diagnosed, the suggestions of Deering et al (Obstet Gynecol 2004;103:1224–8) should also be included.
2. At what stage in the residents’ curriculum should training in operative vaginal delivery be introduced? In which year of a resident’s training is the first operative vaginal delivery done in your institution?

Response from Dr. Edward R. Yeomans:

Training in operative vaginal delivery should be introduced at the beginning of the first year of training and continued throughout all 4 years of residency. In my institution, first-year residents can perform carefully selected operative vaginal deliveries.

3. When in her pregnancy is a woman counseled regarding the risks and benefits of operative vaginal delivery? Is a form used for documenting consent for operative vaginal delivery? What role does patient preference have for selection of the method of operative vaginal delivery?

Response from Dr. Edward R. Yeomans:

Ideally, counseling or education regarding the possibility of operative vaginal delivery should be included in childbirth education classes and prenatal care. We do not currently use a special form to document consent. Patient preference for a method of operative vaginal delivery is less important than operator preference.

4. You did not discuss midforceps rotation. Do you believe that this practice should be abandoned?

Response from Dr. Edward R. Yeomans:

I do not believe that midforceps rotation should be abandoned. I still perform and teach the procedure. Many programs do not.
5. What is your estimate of the accuracy of determining the position of the fetal head by clinical exam? Is there evidence to support that estimate?

**Response from Dr. Edward R. Yeomans:**

*Accurate determination of fetal head position is a learned skill. Through continued practice and constant alertness, a very high percentage of correct diagnoses should be attainable.*

6. The real or perceived threat of litigation is a huge factor in determining the mode of delivery. Is it practical to expect that there will be any significant increase in the rate of operative vaginal delivery outside of selected academic settings?

**Response from Dr. Edward R. Yeomans:**

*The threat of litigation is responsible in large part for the steady decline in the performance of operative vaginal delivery. I do not know whether this trend is reversible, but I do know that far too little attention has been paid to the complications and long-term consequences of cesarean delivery.*

7. What is your opinion of combined vacuum extraction and forceps delivery? Is there ever a situation when this approach is reasonable?

**Response from Dr. Edward R. Yeomans:**

*I discourage the use of combined vacuum and forceps delivery in general, but must concede that there is a marked difference, so far inadequately studied, between switching from vacuum to forceps on the pelvic floor versus switching higher up in the pelvis when the vacuum fails to produce descent of the fetal head. There may be situations, probably infrequent, when technical skill and good clinical judgment may induce the operator to perform combined instrumental delivery.*
8. Is the incidence of subgaleal hematoma related to the duration (time or number of contractions) of the operative vaginal delivery?

Response from Dr. Edward R. Yeomans:

The incidence of subgaleal hematoma varies widely throughout the literature. In my opinion, the occurrence of this potentially catastrophic complication, seen more often with vacuum extraction, has not been reliably linked to duration of the procedure. That said, good judgment would dictate that duration greater than 20 minutes may be imprudent.