of 13 years) after being seen for OSD and treated with at least 2 months of rest. Patients reported undergoing complete rest from training because of pain for an average of 3.2 months, and the disease interfered with fully effective training for 7.3 months. Thirty-five (70%) of the 50 patients were forced to restrict some activities for 10 months on average. Twenty-five (50%) patients had mild tenderness over the tibial tuberosity even after complete ossification had occurred.

Michael Brackman, DO
Patrick Depenbrock, MD
Carl R. Darnall Army Medical Center, FMR
Ft. Hood, TX

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At what point in a normal vaginal delivery should uterotonics be given?

Evidence-Based Answer

During a normal vaginal delivery, no significant differences in clinically important outcomes are noted if uterotonics are given either at delivery of the anterior shoulder or after delivery of the placenta (SOR: A, Cochrane review).

It is common practice to use uterotonics during the third stage of labor to reduce the risk of postpartum hemorrhage, but the timing of these medications has been debated. A Cochrane review included 3 trials (1,671 deliveries) comparing oxytocin given either at delivery of the anterior shoulder or after delivery of the placenta. There was no significant difference in the primary outcome (blood loss >500 mL) between the 2 groups (risk ratio [RR] 0.81; 95% CI, 0.62–1.04). Timing of oxytocin also did not increase the incidence of any of the secondary outcomes: retained placenta (RR 1.5; 95% CI, 0.76–3.1); length of third stage of labor (mean difference [MD] –0.30 min; 95% CI, –0.95 to 0.36); postpartum blood loss (MD 22 mL; 95% CI, –58 to 102); changes in hemoglobin (MD 0.06 g/dL; 95% CI, –0.60 to 0.72); blood transfusion (RR 0.79; 95% CI, 0.23–2.7); or the use of additional uterotonics (RR 1.1; 95% CI, 0.80–1.5).

One double-blind RCT (n=1,486) was so large that it drove the Cochrane conclusion. In this study, there was also no significant difference in the incidence of key outcomes between oxytocin given with delivery of the anterior shoulder or after delivery of the placenta: postpartum hemorrhage (5.4% vs 5.8%; crude OR 0.92; 95% CI, 0.59–1.43); retained placenta (2.4% vs 1.6%; OR 1.49; 95% CI, 0.72–3.08), or third-stage duration (7.7 vs 8.1 min; P=.23).

Using a slightly different protocol, another RCT (n=1,648) compared oxytocin at delivery of the anterior shoulder combined with controlled cord traction versus oxytocin after the delivery of the placenta with no cord traction. There was an overall decrease in the incidence of postpartum hemorrhage (5.8% vs 11%; OR 0.50; 95% CI, 0.34–0.73); retained placenta, defined as >30 minutes (1.6% vs 4.5%; OR 0.31; 95% CI, 0.15–0.63); and requirement of additional uterotonic agents (2.3% vs 5.1%; OR 0.44; 95% CI, 0.24–0.78). Due to the absence of cord traction with the second group, it is difficult to determine if the decrease in postpartum hemorrhage was secondary to timing of uterotonics or the addition of cord traction, or a combination of both.

Matthew Hurley, MD
Marci Moore-Connelley, MD
Southern Illinois University – Carbondale Family Medicine

What is the prevalence of vaginal dryness postpartum and what is the best treatment?

Evidence-Based Answer

The prevalence of postpartum vaginal dryness ranges from 17% by physical exam to 46% by patient report. Breastfeeding doubles the risk of vaginal dryness. For patients requesting treatment, topical estrogens twice a week may be considered (SOR: C, expert opinion and case reports).

In an uncontrolled case series of consecutive primiparous women who delivered in a London teaching hospital, 796 were mailed a survey exploring their general, mental, and sexual health during the postpartum
Among the 484 (61%) women who responded, a lack of vaginal lubrication during the first 3 months after giving birth was reported at higher rates than during the year prior to the pregnancy (46% vs 12%; \(P<.001\)).

A cohort study with 215 women at their 4-week postpartum visit explored the relationship among vaginal pH, vaginal atrophy, and the effect of estrogen therapy. All women underwent an extensive gynecologic history and specialized vulvar/vaginal exam (vestibular cotton swab test, vaginal wall cytology, vaginal wall wet mount, assessment of vaginal tenderness with gentle wall scraping) and measurement of vaginal pH. Thirty-seven women (17%) were diagnosed with vaginal atrophy based on a pH \(\geq 5.3\) along with one symptom or one exam finding consistent with vulvar atrophy. A comparison group of 80 patients without vaginal atrophy was selected. There was a higher rate of breastfeeding in the atrophy group (68% vs 32%; \(P<.001\)). Dyspareunia was also more common in women with atrophy than those without (80% vs 14%; no \(P\) value given). All patients with atrophy were treated with conjugated estrogen vaginal cream 2 g twice a week for up to 40 days, at which point their vaginal pH had dropped below 5.3. No information was provided on whether symptoms were relieved.

In a case report of a 23-year-old primiparous woman at 13 months postpartum, the patient was diagnosed with lactational atrophic vaginitis. The authors reported noticeable improvement in her dysuria, vaginal itching and dryness, and severe pain with intercourse after 2 weeks of treatment with twice- to thrice-weekly 17 beta-estradiol estrogen cream.

In a narrative review, postpartum vaginal dryness was noted to be caused by a relative estrogen-deficient state that may be exacerbated by lactation. The authors recommended topical estrogen, as well as medications typically used for postmenopausal vaginal atrophy—lubricants, vitamin E oil, and botanicals such as phytoestrogens, black cohosh, dong quai, and ginseng.

**Patricia Adam, MD, MSPH**
**Diane J. Madlon-Kay, MD, MS**
Smiley’s Clinic FMRP, U of MN Medical School
Minneapolis, MN