



Perinatal Gazette

Newsletter of the Regional Perinatal Center
Westchester Medical Center



Volume 2, Issue 6

November 2002

Welcome to our new Director of Obstetrics and Gynecology

The Department of Obstetrics and Gynecology would like to announce the appointment of Dr. Chaur-Dong (C.D.) Hsu as the Director of the Department. Dr. Hsu comes from the Department of Obstetrics and Gynecology at the Nebraska Medical Center in Omaha where he was the Director of the Division of Maternal-Fetal Medicine and Head of the Obstetrics Section. He was the Leon S. McGoogan Endowed Chair and Professor at the University of Nebraska College of Medicine as well as the Director of the Maternal-Fetal Medicine Research Lab and Director of the Olson Center for Prenatal Diagnosis. He is currently on the board of Directors of North America Society for the Study of Hypertension in Pregnancy.

He was Associate and Assistant Professor as well as Director of Perinatal Research and Education, and Associate Director of Maternal-Fetal Medicine Fellowship Program at Yale University School of Medicine in New Haven, Connecticut. Prior to that he was an Instructor at John Hopkins University School of Medicine in Baltimore, Maryland.

Dr. Hsu graduated from the Kaoshiung Medical School in Taiwan. He has a Masters of Public Health from John Hopkins University.

Dr. Hsu completed a Residency Program in OB/GYN at Beth Israel Medical Center, New York, NY.

Postpartum Depression

Postpartum depression, the most common complication of childbearing, occurring in approximately 1/8 pregnancies. At nearly 4 million births annually this projects, a half million women to have this disorder every year. Major depression is defined by the presence of five symptoms, one of which must be either depressed mood or decreased interest or pleasure.

1. Depressed mood, often accompanied by anxiety
2. Markedly diminished interest or pleasure in activities.
3. Appetite disturbance
4. Sleep disturbance- most often insomnia and fragmented sleep.
5. Physical agitation or psychomotor slowing.
6. Fatigue, decreased energy.
7. Feelings of worthlessness or excessive guilt.
8. Decreased concentration or ability to make decisions.
9. Suicidal ideation.

The patterns of symptoms in women with postpartum depression are similar to those in women who have episodes unrelated to childbirth. The consequences of parental mental illness also can affect child development.

Postpartum depression must be distinguished from postpartum blues or 'baby blues', which occur in the majority of new mothers. Symptoms such as weeping, sadness, irritability, anxiety, and confusion occur, peaking around the fourth day after delivery, and resolving by the tenth day. This transient mood disturbance does not consistently affect the woman's ability to function. Postpartum depression is defined as an episode of depression it begins within four weeks after delivery. Postpartum psychosis represents a psychiatric emergency that requires immediate intervention because of the risk of infanticide and suicide. Onset usually occurs within the first two weeks after delivery. This disorder differs from other psychotic episodes because it usually involves extreme disorganization of thought, behavior, unusual hallucinations, and delusions, all of which suggest an organic cause. Postpartum psychosis is usually a manifestation of bipolar disorder..

Continues on page 2

INSIDE THIS ISSUE

- 1 - Welcome our New Director of Obstetrics
Postpartum Depression
- 2 - Laser surgery for NICU patients with severe
Retinopathy of Prematurity (ROP)
- 3 - Little Miracles
20th NICU Anniversary Party

Continued from Postpartum Depression

A rapid decline in the levels of reproductive hormones that occurs after delivery is believed to contribute to the development of depression in susceptible women. Several other factors may predispose women to this condition. Stressful life events, past episodes of depression and a family history of mood disorders, are all predictors of major depression in women. The likelihood of postpartum depression does not appear to be related to a woman's educational level, the sex of her infant, whether or not she breast-feeds, the mode of delivery, or whether or not the pregnancy was planned.

For women who are diagnosed with postpartum depression, treatment with anti-depressants is appropriate. A selective serotonin reuptake inhibitor's should be tried initially because such agents are associated with a low risk of toxic effects in patients taking an overdose, as well as ease with administration, and have been used frequently in breast-feeding women. Women with postpartum depression may be more likely to have a response to serotonin reuptake inhibitors and venlafaxine, than to nonserotonergic tricyclic antidepressants. The initial dose of sertraline per day is 25 mg for 4 days, and doses should be increased by small increments (25 mg per week) as tolerated, until full remission is achieved. Slow increases in the dose are helpful in managing side effects. If a patient has a response to the initial trial of medication lasting 6 to 8 weeks, the same dose should be continued for a minimum of 6 months. If there is no improvement after 6 weeks of therapy or if the patient has a response but then has relapses, referral to a psychiatrist is indicated. The average duration of postpartum depression without treatment is 7 months.

PSYCHOTHERAPY: Interpersonal psychotherapy, a 12 session treatment that focuses on changing roles and important relationships, was effective for the relief of depressive symptoms and improvement in psychosocial functioning.

If any of the symptoms are present the patient should contact her physician. The physician should inquire about any depressive symptoms at the time of the postpartum visit. Women with this disorder need not feel alone in their suffering. They may find useful information in Marie Osmond's book Behind the Smile: My journey out of postpartum depression and on web sites of the national Women's health information center (<http://www.4woman.gov>) and groups such as Postpartum Support International.

Satya Polavarapu, M.D.
Fellow-Maternal Fetal Medicine
Westchester Medical Center
Clinical Instructor
New York Medical College
Phone: (914) 493 – 8398
Email: <mailto:SatyaSP@aol.com>

Laser Surgery for NICU patients with severe Retinopathy of Prematurity

Infants who weigh less than 1250 grams (approximately 2 lbs 12 ozs.) at birth are at increased risk to develop Retinopathy of Prematurity (ROP). The retina is the inner lining of the eyeball that receives light and turns it into visual messages that are sent to the brain. Blood vessels that supply the retina are one of the last structures of the eye to mature and have barely completed growing toward the front of the eye when a baby is born at term. A premature baby's retina is incompletely developed. The blood vessels in the immature part of the retina may develop abnormally in some premature infants. In the United States an estimated 1,300 infants annually develop ROP that is severe enough to require medical or surgical treatment. Severe ROP is more likely to develop in the smallest infants.

In the large majority of infants who develop ROP the abnormal blood vessels will spontaneously regress completely during the first year of life. In a small percentage of infants, the ROP may progress and require surgical intervention. Laser therapy is now available for these infants with severe ROP. Laser therapy involves aiming a beam through the pupil to the wall of the retina. The laser beam will destroy a portion of the retina that has not yet received a supply of blood vessels. Destroying this part of the retina decreases the growth of abnormal blood vessels and often stops the progression of the disease. The procedure is applied as many times as necessary to destroy the entire part of the retina without blood vessels.

Dr. Marc Horowitz a pediatric ophthalmologist, in the RNICU, screens infants whose birth weight is less than 1250 grams between 28 and 42 days after birth. Laser therapy is carried out in the Regional Neonatal Center at the baby's bedside with the neonatal healthcare team and a retina specialist. **For any questions, please call WMC NICU for information on the ROP study at (914) 493-8585.**

Happy Holiday's to all...



Little Miracles

The story below highlights some of the uncertainties associated with the NICU experience, as seen through the eyes of parents. In spite of the fact that the "tower of strength" Aaron had a relatively "mild" respiratory course in the NICU from the doctors' perspective, it was truly a "roller coaster" for the family.

The NICU at Westchester Medical Center cares for the most extremely premature infants weighing less than 1000 grams (about 2 pounds, 3 ounces) in the entire State of New York. Outcomes for these babies are amongst the best in the nation. These results are due to a concerted effort from parents; referring Obstetricians, Pediatricians and Neonatologists; Maternal-Fetal Medicine colleagues at Westchester Medical Center; and the team of healthcare providers in the NICU.

It is truly remarkable to compare the "before" and "after" picture of Aaron in this "Story of Hope..."

"You're going to be a Daddy tonight," said Grace, our Labor & Delivery nurse, to my husband before she ended her shift that night. Nobody wanted to tell me that however. I had been in labor for three days, and no matter what drug I was put on to stop my contractions, they kept coming full force. My contractions needed to stop because I was only 24 weeks pregnant.

My due date was August 11th; however, my son, Aaron (our first child), was born on April 26th – 15 and a half weeks premature. Why was he born so early? What was going to happen to him? Was he going to make it? All of these questions were running through my head when he was born. Why us? Why was this happening to us?

I had steroid injections while in labor to enhance the development of the baby's lungs and brain. They must have worked because Aaron came out crying when he was delivered. There was a team of neonatal doctors waiting behind me for the baby. But before they took him to the NICU, they held him up to my face so I could see him and I'll never forget that moment. He was so beautiful, so tiny. I couldn't believe that he was here already. I was scared to touch him. He was so little and so fragile. He was just 1 lb.13 oz. at birth and 13" long. My husband got to hold him for a few moments, and then they brought him to the NICU. My husband and I didn't even know what a NICU was until our son was born.

The next day, I went to see him. I certainly was not prepared, however, for what I saw. Such a tiny person fighting for his life in an incubator. It just wasn't fair. When I found out I was pregnant, my husband and I were so thrilled. We never in a million years thought it would be this difficult.

Continues top of page 3

Continued from Little Miracles

All the nurses in the NICU told us that we would be there for the long haul. They were right. They all said it is going to be a day-by-day process. They were right about that too. I remember Aaron doing so well one day, and the next day he needed another blood transfusion. I would call the NICU every night before I went to bed and every morning to see if he gained any weight. Twenty grams here, five grams there. At first, I couldn't comprehend when he would lose weight. Why was this little person who can't afford to lose weight, losing weight? Again, it just didn't seem fair.

After 98 days in the hospital, and after all of the tests, X-rays, head ultrasounds, catscan, needles, heel sticks, IV's, spinal tap, blood transfusions, chest p/t's, weeks on CPAP and nasal cannula, infections and treatments, endless weight gain and loss, and most importantly after all of the Kangaroo Care and love, Aaron finally came home on August 1st! We never thought we'd see the day. He came home at 5 lbs. 7 ½oz. and 18" long. He was a healthy baby that looked like a newborn (even though he was already 3 months old). He truly is our miracle baby!

It was a long haul, just like all the nurses had told us. He received such phenomenal care in the NICU and in the Special Care Nursery at WMC. All the nurses and doctors that cared for him saved his life. It really is amazing what they can do with premies today. Aaron is living proof. His is an amazing story, and hopefully other parents going through the same thing that my husband and I went through will have faith to know that their babies are in the best care and will make it too".



Lance A. Parton, M.D.
Attending in Neonatology
Westchester Medical Center
New York Medical College
Phone: (914) 493-8558

Email: mailto:Lance_parton@nymc.edu

20th NICU Anniversary

On September 19, 2002 The Regional Neonatal Center celebrated 20 years of providing care to families in the Hudson Valley Region. Some 300 "graduates" and their families attended this special event, which included 22 sets of twins, 8 sets of triplets and 1 set of quads. The air was full of excitement as the families were reunited with the staff that cared for their babies. Children were playing on the inflatable ride, laughing, of course eating and enjoying all of the special activities for them. Seeing these miracle babies grow and flourish is rewarding as well as motivating for the staff. The healthcare team of The Regional Neonatal/Perinatal Center is proud to have contributed to their survival.

A 20th Anniversary Program hosted by Dr. Edmund La Gamma featured Tim Dyer, a now 16 year old, who was transferred to the RNICU in 1986 for care and treatment. Tim is an honor student at Putnam Valley High School and active on several sports teams. Remarks were heard from, Edward Stolzenberg President and CEO of Westchester Medical Center, Gene Capello, Chairman of the Board of Westchester County Health Care Corporation, Alfred DelBello, Westchester County Commissioner at the time of the establishment of the RNICU, Michael Gewitz, M.D., Director of Pediatrics, Children's Hospital at Westchester Medical Center, and Bruce Komiske, Executive Director, Children's Hospital Foundation. Claire and Sam Polk, made a generous donation to the RNICU in memory of their son, Randy Polk. Dr. La Gamma distributed Founder's Awards and Leonard Newman, M.D., Chairman of Pediatrics, New York Medical College and Honorable Richard Brodsky presented a sign to honor the establishment of the RNICU in 1982.

State Perinatal Database Team & Perinatal Gazette Editorial Board

Edmund LaGamma, M.D., Director Newborn Medicine

(914) 493-8558 (edmund_lagamma@nymc.edu)

Chaur- Dong (C.D.) Hsu, M.D., M.P.H., Director OB/GYN

(914) 347-4139 (mailto:chaur-dong_hsu@nymc.edu)

Susan Marchwinski, R.N., C., M.S., SPDS Coordinator

(914) 493-8590 (marchwinskisa@wcmc.com)

Donna Dozor, R.N., M.S. Neonatal Data Collection

(914) 493-8309 (dozord@wcmc.com)

Nancy Satou, R.N. Maternal Data Collection & Editor

(914) 493-8346 (satoun@wcmc.com)

We are interested in providing you with a newsletter that is relevant and of interest to you. Please contact us with perinatal topics you would like to see addressed.

For a copy of our newsletter or to be placed on our mailing list contact us by phone or e-mail.

Please see below the NYMC neonatal web site address to locate other issues of The Gazette:

<http://www.nymc.edu/neonatology>

Children's Hospital at Westchester Medical Center

95 Grasslands Road

Valhalla, New York 10595

Phone: 914-493-8590

Fax: 914-493-1493

E-mail: dozord@wcmc.com satoun@wcmc.com

marchwinskisa@wcmc.com

ADDRESS CORRECTION REQUESTED

