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(英文原版)

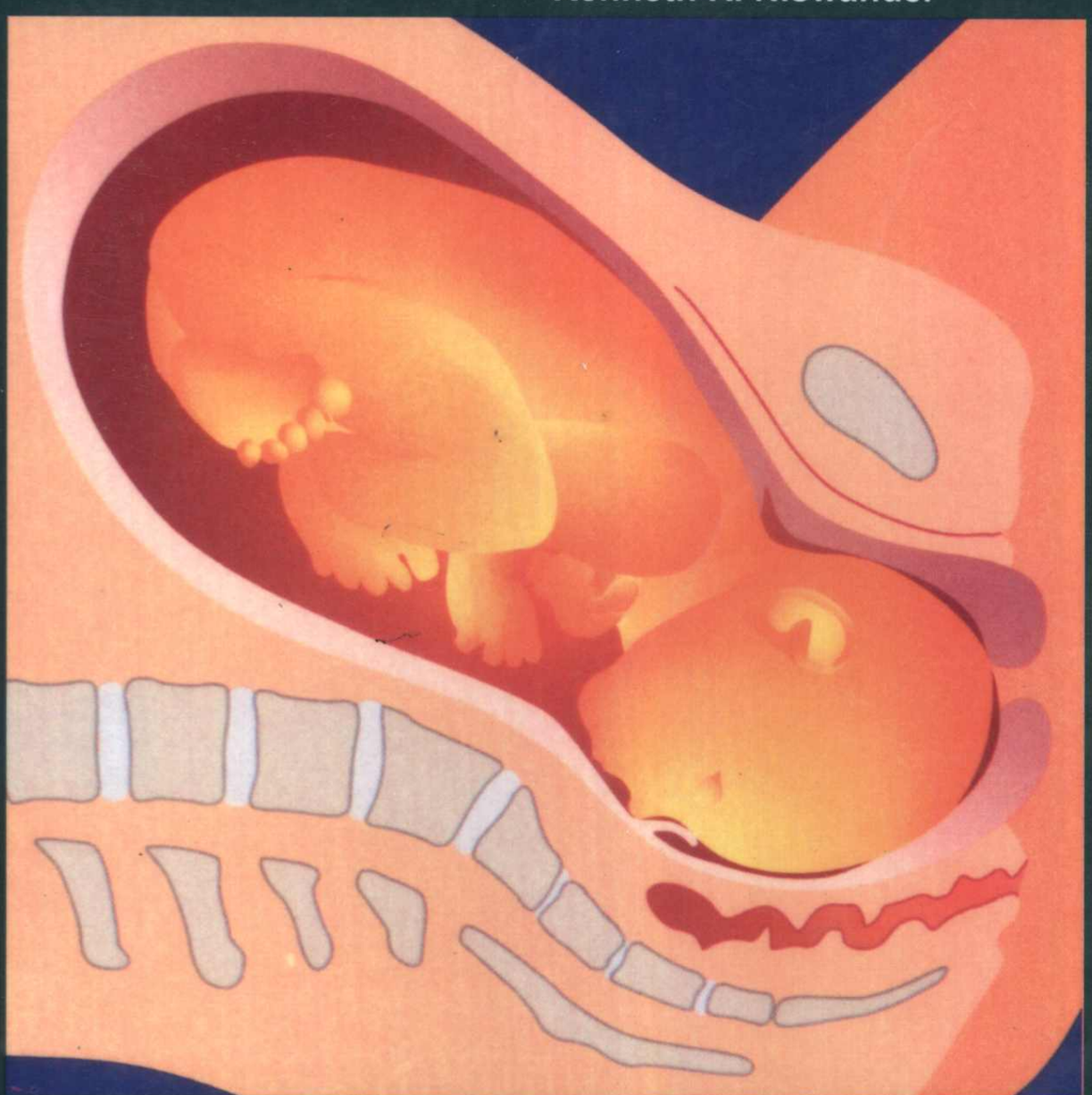
Manual of Obstetrics

Sixth Edition

配英汉索引

产科学手册

Edited by
Arthur T. Evans
Kenneth R. Niswander



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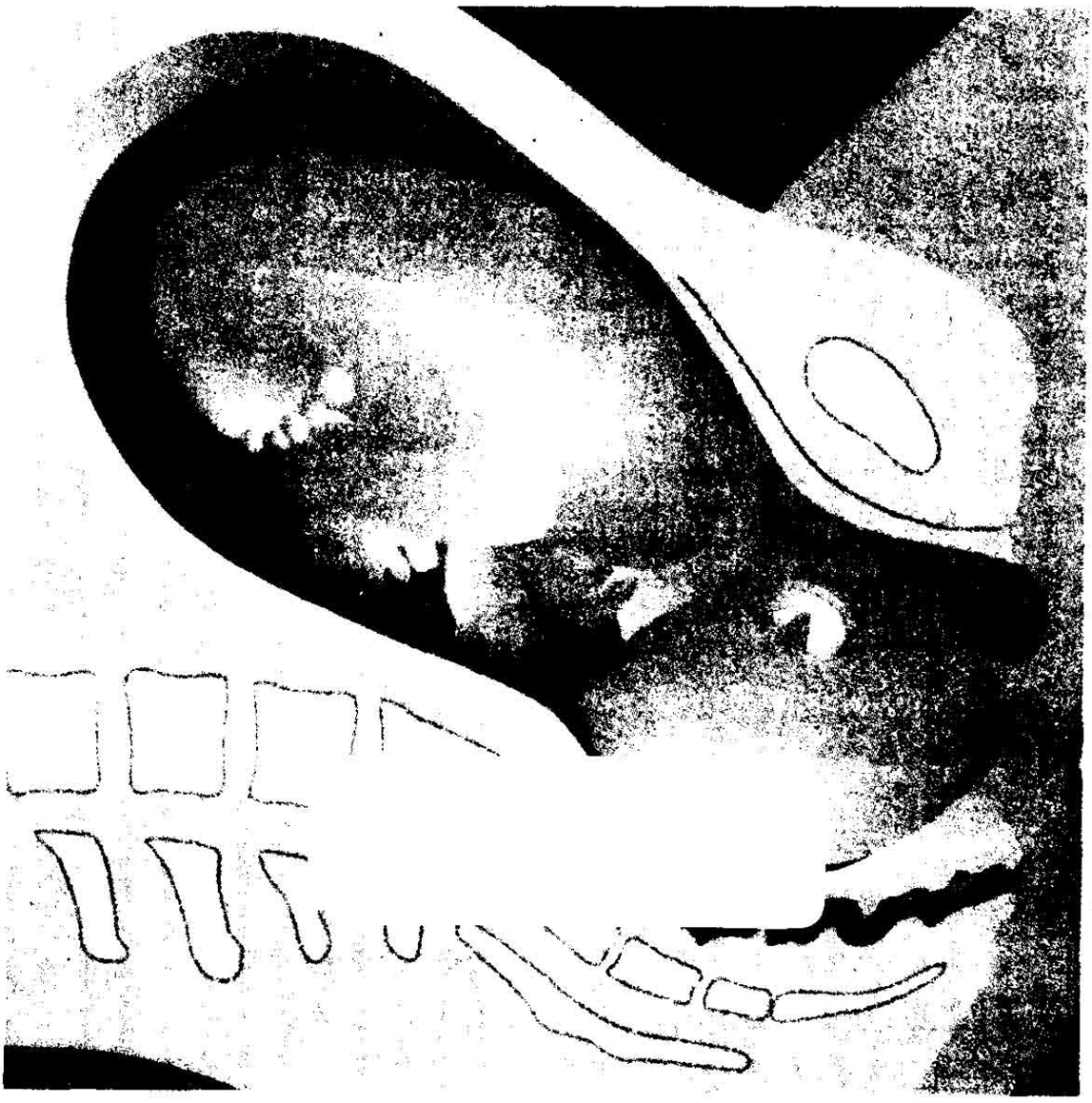

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天津科技翻译出版公司出版

著作权合同登记号:图字:02-2002-86

图书在版编目(CIP)数据

产科学手册 = Manual of Obstetrics/(美)埃文斯(Evans, A. T.),(美)尼斯旺德(Niswander, K. R.)编著 .—影印本 .—天津:天津科技翻译出版公司,2003.1
(SPIRAL® MANUAL 系列丛书)
ISBN 7-5433-1616-1

Ⅰ. 产... Ⅱ. ①埃... ②尼... Ⅲ. 产科学－手册－英文 Ⅳ. R714－62

中国版本图书馆 CIP 数据核字(2002)第 073121 号

授权单位: Lippincott Williams & Wilkins Inc.
出　　版: 天津科技翻译出版公司
出 版 人: 邢淑琴
地　　址: 天津市南开区白堤路 244 号
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印　　刷: 天津市蓟县宏图印务有限公司印刷
发　　行: 全国新华书店
版本记录: 900×1168　32 开本　18 印张　550 千字
2003 年 1 月第 1 版　2003 年 1 月第 1 次印刷
定价:45.00 元

(如发现印装问题,可与出版社调换)

Manual of Obstetrics

SIXTH EDITION

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LIPPINCOTT WILLIAMS & WILKINS
A **Wolters Kluwer** Company
Philadelphia • Baltimore • New York • London
Buenos Aires • Hong Kong • Sydney • Tokyo

Acquisitions Editor: Lisa McAllister
Managing Editor: Susan Rhyner
Production Editor: Jeff Somers
Manufacturing Manager: Kevin Watt
Cover Designer: Patricia Gast
Compositor: Circle Graphics
Printer: RR Donnelly-Crawfordsville

530 Walnut Street
Philadelphia, PA 19106 USA
LWW.com

Printed in the USA

Library of Congress Cataloging-in-Publication Data

Manual of obstetrics / edited by Arthur T. Evans, Kenneth R. Niswander.—6th ed.
p. ; cm.
Includes bibliographical references and index.
ISBN 0-7817-2404-X (alk. paper)
1. Obstetrics—Handbooks, manuals, etc. I. Evans, Arthur T. II. Niswander, Kenneth R., 1924–
[DNLM: 1. Obstetrics—Outlines. 2. Contraception—Outlines. 3. Perinatology—Outlines. 4. Pregnancy Complications—Outlines. WQ 18.2 M294 2000]
RG531 .M294 2000
618.2—dc21 99-048129

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10 9 8 7 6 5 4 3 2 1

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PREFACE

Obstetric practice in the United States is changing at an increasingly rapid pace as American healthcare evolves. In this environment, obstetric practitioners frequently need a pragmatic and concise source of information in the course of their demanding daily clinical work. The 6th Edition of the *Manual of Obstetrics* has been significantly revised and updated to reflect these changes and needs.

As in previous editions of the Manual, the chapter authors of the 6th Edition are physicians who are actively practicing obstetrics and understand what the busy practitioner needs to know. The intended audience continues to be medical students, residents (particularly in obstetrics and gynecology, family practice, and emergency medicine), and physicians providing obstetric care who want a concise reference on obstetric management issues. Other healthcare professionals working in obstetrics—nurse midwives, obstetric and emergency room nurses, sonographers and others—have also used previous editions and we hope this will continue.

All of the chapters in the 6th Edition have been edited to bring them up-to-date with current practice.The tradition of bringing on new authors with respected clinical experience continues with this edition of the Manual, with nearly half of the chapters having new authors. As with previous editions, specific attention has been given to providing pragmatic recommendations on clinical management and drug doses. The chapters on Endocrine Disorders, Infectious Disease Complications, Neurologic Complications, and Dermatologic Complications have been extensively rewritten. A new chapter on Multiple Gestation has been added in response to the impact of reproductive technologies and the increased incidence of multiple birth. Bibliographic references have been updated in all chapters.

The 6th Edition of the *Manual of Obstetrics* is truly the result of a team effort. My co-editor, Dr. Arthur T. Evans, should receive credit for managing the majority of the organizational and editing work for the 6th Edition. Special recognition goes to Colleen Sliffe for her secretarial assistance and detailed attention to organization of the manuscript. Most importantly, we thank the chapter authors of the 6th Edition of the Manual, to whom the credit is owed. Without their efforts in the midst of their busy clinical schedules, the 6th Edition could not have been completed. Finally we thank our families and our clinical partners for supporting us through this effort.

It is with great sadness that we note the passing of one of our authors, Dr. Mark Morgan. Dr. Morgan was a highly respected colleague and a valued friend. He will be sincerely missed, but he remains with us through the quality of his work and the spirit of his friendship.

K. R. N.
A. T. E.

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I. PREGNANCY

1. CONTRACEPTION, ABORTION, AND STERILIZATION

H. Trent MacKay

Fertility control should be considered an integral part of health care. Although no perfect contraceptive exists, a wide range of methods are available, and almost every couple should be able to find a method that suits their needs. However, to choose a contraception method intelligently, couples need information and advice from their medical care provider. They will want to know the effectiveness, the shortcomings, the dangers, and the expense of the devices or drugs from which they can choose.

I. **Contraceptive failure.** A study by Trussel and Kost (1,2) provided a comprehensive review of the literature. Unfortunately, there is much conflicting information, and many of the studies of contraceptive efficacy or failure have serious methodologic flaws. However, the authors have used the existing information to develop Table 1-1. The perfect use rate represents the authors' "best guess" of the failure rate during the first 12 months of use among couples who use the method perfectly. The typical rate is the rate of failure among average users who experience an accidental pregnancy in the first year of use. The lowest reported rates are those reported in the literature. Unfortunately, most of the lowest reported rates for periodic abstinence methods are probably too low because they include data for more than one year of use. In counseling patients about contraceptive choice, it is important to recognize one's own biases about the methods. It is fairly common for counselors to quote lowest expected or lowest reported failure rates for methods that they favor while quoting typical rates for those they disfavor.

II. **Available agents**

A. **Oral contraceptives.** Oral contraceptives are potent steroid medications that prevent pregnancy primarily by inhibiting ovulation Either an estrogen or a progestin alone in a sufficiently large dose will prevent ovulation, but they are usually combined because the dose of either medication alone that is necessary to prevent ovulation causes an unacceptably high rate of breakthrough bleeding or other undesirable side effects.

With combination therapy, a tablet containing both agents is taken for 21 days, beginning between the first and fifth days of the initial menstrual cycle or on the first Sunday after the menses begin. The primary antifertility effect is mediated by the progestin, which prevents ovulation and effects changes in the endometrium and the cervical mucus. The estrogen is added principally to decrease the number of days of vaginal bleeding experienced by the patient. Triphasic pills contain different doses of progestin, and in some cases estrogen, in each 7-day segment of the cycle and allow a reduction in hormone dose from the levels found in the monophasic pills. Preparations containing only a progestin are also available. The antifertility effect of this drug is somewhat lower than that of the combination pills, and the incidence of breakthrough bleeding is substantially higher. The major advantage of these pills is the lack of side effects caused by estrogen.

1. **Effect on various organ systems.** In addition to their infertility activity, oral contraceptives exert effects on many other organ systems. These effects are important for a number of reasons. Certain organ function tests are altered substantially by oral contraceptives, thus complicating the diagnosis of disease in these organs during oral contraceptive use. Contraindications to the use of pills frequently are based on the pills' effects on a particular organ system. The side effects of the pills may result from an undesirable action of the drug on certain organs.

   a. **Effect on reproductive organs.** Ovulation is prevented, thus decreasing the number of patients with functional ovarian cysts,

Table 1-1. Contraceptive failure rates

Method	Percentage of women experiencing an accidental pregnancy in the first year of use	
	Perfect use	Typical use
Chance	85.00	85.00
Spermicides	6.00	26.00
Periodic abstinence		25.00
Ovulation method	3.00	
Symptothermal	2.00	
Calendar	9.00	
Withdrawal	4.00	19.00
Cervical cap		
Parous women	26.00	40.00
Nulliparous women	9.00	20.00
Diaphragm	6.00	20.00
Condom		
Female	5.00	21.00
Male	3.00	14.00
IUD		
Progestasert	1.50	2.00
T-Cu 380A	0.60	0.80
Pill		5.00
Combined	0.10	
Progestin only	0.50	
Depo-Provera	0.30	0.30
Norplant	0.05	0.05
Female sterilization	0.50	0.50
Male sterilization	0.10	0.15

Adapted from Trussell J, et al. Contraceptive failure in the United States: An update. *Stud Fam Plan* 1990;21(1):51, and from Hatcher et al. (1).

although there is less suppression of ovarian cysts with the low-dose monophasic and triphasic pills. Combined therapy usually produces a secretory effect on the endometrium, and this may produce marked glandular suppression and amenorrhea. Although the earlier, high-dose combination pills frequently produced enlargement of leiomyomas, the low-dose pills with less than 50 mg estrogen do not have this effect. There is some controversy about the relationship of pill use and the development of cervical dysplasia and carcinoma (3). Breast tenderness is a well-recognized side effect of oral contraceptives, caused primarily by the estrogen. Oral contraceptives decrease the incidence of benign breast disease. Although there is no evidence of an overall increase in the risk of breast cancer with pill use, the pill may accelerate the development of preexisting breast cancers in young women. If given during the postpartum period, combination, but not progestin-only, pills may decrease milk production as well as the milk's protein and fat content. Pill use apparently decreases a woman's risk of experiencing serious pelvic infection by approximately 50% (4).

b. Effect on other endocrine organs. Estrogen increases the amount of circulating binding globulins, thus increasing the total amount of bound circulating hydrocortisone and thyroxine. Because these increases are in the bound fraction of the hormone, no recognized change occurs in either adrenal or thyroid function. Although low-