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Secretariat Address
POH Building, Ground Floor
Keramat Street 49A/1, Central Jakarta, 10450, Indonesia

Telephone: 021-3916670, Facsimile: 021-3916671
E-mail: iog.indonesia@gmail.com; majalah_iog@yahoo.com
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Pedoman untuk penulis

Indonesian Journal of Obstetrics and Gynecology memerlukan sumbangan tulisan dari para dokter di sebab Indonesia yang terletak dalam kawasan dan kandungan, dalam bentuk laporan penelitian, tinjauan pasti, atau laporan kasus. Harus terhima kebenaran penulisan dan tidak ada dilarang. Penulis harus mengikuti panduan penulisan sebagai berikut:

1. Judul harus jelas, spesifik, informatif dan singkat (tidak melebihi 40 huruf dan spasi).
2. Nama Penulis, harus menyertakan nama lengkap penulis, alamat lapang, nama dan alamat departemen.
3. Abstract, kepanjangan ringkas (tidak lebih dari 250 kata) dari latar belakang, tujuan, metode, hasil dan kesimpulan yang diperoleh. Kata kunci (5 - 10 kata) harus disebutkan di awal abstract.
4. Pendahuluan, mempersiapkan latar belakang masalah, atau cara penelitian, tujuan, pandangan penelitian, serta proposisi dalam massa data.
5. Metode, menjelaskan penyusunan tentang bagaimana dan alasan pertemuan. Metode harus jelas untuk memandu peneliti lain untuk melakukan penelitian yang sama. Untuk metode yang kurang jelas harus dibahas dalam penyelidikan.
7. Diskusi, menyebutkan maupun hasil pembahasan, dengan cara bagian mana hasil disajikan dapat diperoleh maksimal, pelibatan dan kasus dan kasus dalam satu atau lebih dan kesimpulan yang dibutuhkan. Tabel dan urutan yang lebih jelas atau lebih baik adalah sebagai bagian dari penelitian.
9. Pendahuluan penulisan laporan penelitian
Laporan penelitian harus dikirim dalam format sah. Berikut judul: judul, nama penulis, alamat, pendahuluan, tujuan, metode, hasil yang disajikan dalam bentuk rujukan, referensi.
10. Pendahuluan penulisan tinjauan pasti
Tinjauan pasti harus dibuat dalam format seperti: judul, nama penulis, alamat, pendahuluan, tinjauan, diskusi.
11. Pendahuluan penulisan laporan kasus
Laporan kasus harus dibuat dalam format seperti: judul, nama penulis, alamat, pendahuluan, kasus, dan manajemen kasus yang dikelompokkan dalam foto/rujukan, disajikan dalam bentuk rujukan, referensi.

12. Pendahuluan penulisan lain
Bagian awal harus dibuat dalam format seperti: judul, nama penulis, alamat, pendahuluan, tinjauan, diskusi.

Setiap artikel harus memiliki gambar profil. Foto warna atau wajah pas yang diterbitkan harus jelas baik dalam atau dalam format foto. Layar dengan area minimum 135 x 195 mm. Layar harus disesuaikan dengan format dokumen, atau dari foto dan dibuat menggunakan program MS Word. Rasio penutur mungkin untuk membantu penulis. Teks dalam mungkin tidak lebih dari 12 kolom. Baris kiri, kanan, atas, dan bawah harus 2.5 cm atau 1 inci. Baris terakhir mungkin kurang, mungkin artikel perlu masa kritis, kritis, dan kontroversial. Jika itu dan istilah yang menjelaskan atau penulisan yang lebih jelas, harus disertakan dalam referensi. Setiap artikel harus diberikan gambar profil. Foto warna atau wajah pas yang diterbitkan harus jelas baik dalam atau dalam format foto. Layar dengan area minimum 135 x 195 mm.
Looking Back: What We Have Done and What We Should Do Next

The Correlation between Calcium Serum and Calcium Urine Level with the Blood Pressure in Preeclampsia
There is a negative correlation between calcium serum level and calcium urine level with systolic and diastolic pressure in preeclampsia, meaning that the lower the calcium serum and calcium urine level is, the higher systolic and diastolic pressure.

Maternal Mortality and Contributing Risk Factors
The most contributing risks factors for maternal mortality were maternal education and residence.

Malaria Detection using Polymerase Chain Reaction (PCR) Method in Pregnant Women’s Saliva on Several Hospitals in North Sulawesi Province
The incidence of malaria in pregnancy at various hospital in North Sulawesi using PCR methods for saliva examination from April 1 - May 31 2008 is 5.34%. In this study malaria are mostly caused by Plasmodium falciparum with the largest incidence in primigravida, in the first trimester.

The Identification of Placental Alpha Micro Globulin-1 (Annusire®) as a Method to Identify Rupture of Membrane
For every positive vaginal pooling, nitrazine and Annusire® will be tested positive. Several studies using Annusire®have shown similar results. Role of Annusire®seems evident in cases of uncertainty such as chronic ROM and severe oligohydramnios due to ROM. Positive results in presence of intact membranes which suggested micro-perforations of the membrane still need further research. Much still needed to be done before implementing Annusire® in our country, especially in the matter of cost effectiveness.

Neonatal Haemoglobin and Haematocrit: Level on Delayed Cord Clamping
Delays in cord clamping until at least two minutes after delivery could increase haemoglobin level on newborn babies. Therefore, this method was suggested for every delivery in area where there is a risk of anemia in neonates such as Indonesia.

Comparison between Vacuum and Forceps Extraction on Prolonged Second Stage of Labor
There is no difference of effectiveness between forceps extraction and vacuum extraction in the case of prolonged second stage. Physicians are free whether to use the vacuum or forceps according to their own desirability and skill.

The Effect of Polymorphisms of Estrogen Receptor βRS1271572 to the Incidence of Epithelial Ovarian Carcinoma
Polymorphism of estrogen receptor β may play a role in the risk of epithelial ovarian carcinoma at Dr. Mohamad Husin Hospital Palembang.

Acute Toxicity and Outcomes of Radiation Alone Versus Concurrent Chemoradiation for Locoregional Advanced Stage Cervical Cancer
The response to CRT and RT for locoregional advanced cervical cancer was not different in 3 month evaluation. Acute gastrointestinal, proctitis, and hematologic toxicities found in CRT were higher than in RT (p=0.000; p=0.000; p=0.000).

Level of Education as the Determinant Factor of Obstetric Outpatients’ Knowledge about Intra Uterine Device in Kramat Jati Public Health Center
Level of education are the determinant factor of obstetric outpatients’ knowledge about intra uterine device in Kramat Jati Public Health Center.

Manual Reposition of Uterine Inversion with Hemorrhagic Shock in Minimal Facilities Situation
Uterine inversion can be promptly recognized in the third stage of parturition. Manual manipulation aided by tocolytics or without tocolytics agents is often successfull in correcting the inversion. Shock condition that accompanied the inversion must be vigorously treated, as it would lead to serious maternal morbidity and mortality. Management of acute uterine inversion seems to be depended on the clinical situation and clinical judgment which is very important in every emergency case.
INTRODUCTION

It is estimated that there are 3.6 billion people in the world who were experiencing iron deficit. Two billion of them were anemic. Unfortunately most of them were women on reproductive age and children above 5 years of age in developing country.\(^1\) Anaemia in children is often caused by the lack of iron substance in diet. The effort to overcome this issue by supplementation and fortification seems failed or show little success, especially on developing and poor country.

This problem ignites the idea of enhancing iron storing as early as during the delivery of the child. On delivery, when the baby takes their first breath, there was a huge transition on the lungs. In uterus, fetal lung was an organ filled with and produced liquid about 400 ml/day.\(^5\) During the end of third semester, the fluid production was decreased but
not ceased. Thus, at birth, the newborn’s lung must make immediate dramatic changes in both function and structure. The lung function must change from a fluid-producing organ in the fetus to one of gas exchange in the neonate. The lung structure must change from the fluid-filled state in the fetus to that of open gas-filled alveoli with excellent capillary circulation.

The lungs are compressed during delivery. This compression allows liquid on the lung to strike out. After the baby is delivered, the lung is opened with air and the function is changed to oxygen exchange during neonatal period.

At this time, the blood from fetoplacental circulation is transfused to the neonate’s circulation. This transfusion happens as long as the umbilical cord is not clamped yet. Delaying cord clamping is assumed to hold the transfusion even longer and therefore will enhance the blood volume of the newborn babies. This extra blood volume will add iron store in the body, and reducing the risk of anaemia.

METHOD

During March until June 2011, forty women were included in the trial at obstetric ward of Dr. Moh. Hoesin hospital of Palembang. Women at 37-42 weeks gestational age who were undergoing normal labor were recruited. The inclusion criteria were women with singleton pregnancy at 37-42 weeks gestation and underwent normal labor without any complication. The exclusion criteria were preeclampsia, history of antepartum haemorrhage, anemic mother (Hb < 10 g/dl) and other than cephalic presentation. If after delivery, the baby needs resuscitation, it will directly be excluded from the trial. The sample was drawn from venous blood of umbilical cord. Through simple random sampling, each of the subject receive sealed envelope, which divide the mother into two groups. The first group was assigned to early cord clamping group. After delivery, the cord was clamped as early as 10 seconds after whole body of the baby was born (early cord clamping group). The second group was assigned to delayed cord clamping until two minutes. The haemoglobin and haematocrit level of the two groups and the mother were noted and compared using Mann-Whitney U test. The characteristic of the mother was compared using Pearson Chi Square and Fisher Exact test. Data were analysed using SPSS 16 for Windows.

RESULT

The characteristic of the mother was shown at Table 1.

<table>
<thead>
<tr>
<th>Table 1. Material Characteristic</th>
<th>Early cord clamping</th>
<th>Delayed cord clamping</th>
<th>P</th>
</tr>
</thead>
<tbody>
<tr>
<td>Maternal Age</td>
<td>n</td>
<td>%</td>
<td>n</td>
</tr>
<tr>
<td>&lt; 20 years</td>
<td>5</td>
<td>25</td>
<td>1</td>
</tr>
<tr>
<td>20-38 years</td>
<td>12</td>
<td>60</td>
<td>12</td>
</tr>
<tr>
<td>39-45 years</td>
<td>7</td>
<td>35</td>
<td>7</td>
</tr>
<tr>
<td>&gt; 40 years</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Total</td>
<td>20</td>
<td>100</td>
<td>20</td>
</tr>
<tr>
<td>Maternal Education</td>
<td>n</td>
<td>%</td>
<td>n</td>
</tr>
<tr>
<td>≤ 9 years (SD-5MP)</td>
<td>14</td>
<td>70</td>
<td>6</td>
</tr>
<tr>
<td>10-15 years (SMA-LDS)</td>
<td>6</td>
<td>30</td>
<td>14</td>
</tr>
<tr>
<td>&gt; 15 years (S-53)</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Economic Status</td>
<td>n</td>
<td>%</td>
<td>n</td>
</tr>
<tr>
<td>Low</td>
<td>10</td>
<td>50</td>
<td>3</td>
</tr>
<tr>
<td>Medium</td>
<td>10</td>
<td>50</td>
<td>17</td>
</tr>
<tr>
<td>High</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Party</td>
<td>n</td>
<td>%</td>
<td>n</td>
</tr>
<tr>
<td>1-3</td>
<td>18</td>
<td>90</td>
<td>18</td>
</tr>
<tr>
<td>&gt; 3</td>
<td>2</td>
<td>10</td>
<td>2</td>
</tr>
<tr>
<td>Gestational Age</td>
<td>n</td>
<td>%</td>
<td>n</td>
</tr>
<tr>
<td>37-38 weeks</td>
<td>12</td>
<td>60</td>
<td>7</td>
</tr>
<tr>
<td>39-40 weeks</td>
<td>28</td>
<td>138</td>
<td>13</td>
</tr>
</tbody>
</table>

*Tested with Pearson-Chi Square
*Tested with Fisher Exact Test

Most of the women included in this trial aged between 20-30 years with 1-3 parity. The number of women with 39-40 weeks of gestational age was higher than 37-38 weeks. Women on delayed cord clamping groups seemed to have higher education level with p=0.01. Maternal economic status was statistically different between the two groups.

Maternal haemoglobin, haematocrit and erythrocyte level is shown in Table 2.

<table>
<thead>
<tr>
<th>Table 2. Maternal Haemoglobin, Haematocrit and Erythrocyte Level</th>
<th>Early cord clamping</th>
<th>Delayed cord clamping</th>
<th>P</th>
</tr>
</thead>
<tbody>
<tr>
<td>Blood</td>
<td>n</td>
<td>x±SD</td>
<td>n</td>
</tr>
<tr>
<td>Haemoglobin (g/dl)</td>
<td>20</td>
<td>11.3±0.751</td>
<td>20</td>
</tr>
<tr>
<td>Haematocrit (%)</td>
<td>20</td>
<td>33.9±2.892</td>
<td>20</td>
</tr>
<tr>
<td>Erythrocyte (million)</td>
<td>20</td>
<td>3.7±0.392</td>
<td>20</td>
</tr>
</tbody>
</table>

*Tested with Mann-Whitney U test

The median maternal haemoglobin in the delayed cord clamping group was 11.28 g/dl, while in the early cord clamping was 11.1 g/dl. There is no difference between the two groups. This will minimize the bias between the subjects. The haematocrit and erythrocyte level were all the same.
Table 3 shows the neonatal haemoglobin, haematocrit and erythrocyte level of the two groups.

<table>
<thead>
<tr>
<th>Blood</th>
<th>Early cord clamping</th>
<th>Delayed cord clamping</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>n</td>
<td>±SD</td>
</tr>
<tr>
<td>Haemoglobin (g/dl)</td>
<td>20</td>
<td>14.36±1.812</td>
</tr>
<tr>
<td>Haematocrit (%)</td>
<td>20</td>
<td>43.35±5.678</td>
</tr>
<tr>
<td>Erythrocyte (million)</td>
<td>20</td>
<td>4.63±8.525</td>
</tr>
</tbody>
</table>

Neonatal haemoglobin level on delayed cord clamping was higher from early cord clamping group. The median haemoglobin was 15.77 g/dl and 14.36 g/dl in the DCC and ECC group, respectively. There were statically significant different between two groups (p=0.005). Neonatal haematocrit and erythrocyte level of the two groups were similar.

DISCUSSION

Maternal haemoglobin was all the same between these two groups. Unfortunately this trial did not examine maternal post partum hematologic status. Other trial such as McDonald's trial didn't find any difference on maternal post partum hematologic status, indicating that there are no haemorrhagic post partum happen during the delay of cord clamping.

Gupta{4} and Enhamed{5} delayed cord clamping on anemic mother, and followed up the neonates' hematologic status, which shows that the iron store on delayed cord clamping baby increased until 3 months after delivery.

Neonatal haemoglobin level on delayed cord clamping is higher than the early cord clamping group.{6} Longer time of delaying cord clamping seems to make haemoglobin become higher, even in preterm babies.{7,8}

This trial revealed that even though there was a higher haemoglobin level on delayed cord clamping groups, the haematocrit level seems to be the same. It could be caused by the higher estimated neonatal blood volume on the newborn babies. The difference with other trial is because the time of delaying cord clamping was different.{9,10}

Delaying cord clamping should be preferred during delivery in the condition of poor setting or if the incidence of anaemia on baby was high.{11} But other complications of delaying cord clamping such as polisitemia and the need for phototherapy on newborn baby should also be considered. On the Cochrane study, it revealed that even though the incidence of polisitemia status was higher on delayed cord clamping group, the result was not statistically significant.{12}

REFERENCES