



FEBRUARY 2009

"FOR THE OBESE GRAVIDA, TRY STRONG COUNSELING AND CLOSE FOLLOW-UP"

"DELIVERY AND POSTPARTUM CONCERNS IN THE OBESE GRAVIDA"

JULIE PHILLIPS, MD, AND JANICE HENDERSON, MD
(FEBRUARY 2009)

Estimating fetal weight is difficult in obese women

I enjoyed the articles on obesity in pregnancy and would like to add one point. Ultrasonographic imaging in the obese gravida is often poor. I suggest that the anatomic survey, usually recommended for 18 to 20 weeks of gestation, be postponed to 22 to 24 weeks in this population. True, you may miss the opportunity to assess the nuchal fold, but that is not so important if you also perform first-trimester genetic screening.

The new transducer being advertised by Philips for their iU22 ultrasound system may make this suggestion less important (I don't know—I have not used it). In time, it is likely that all machines will do a better job of imaging in the obese patient, but there is, for now, an enormous difference in the quality of imaging be-

tween thin and obese patients.

Because of this problem, there is a great likelihood that something will be missed in the obese gravida. I also tend to have less confidence in fetal biometry in this population, particularly in the third trimester.

Joseph A. Worrall, MD, RDMS
Fairbanks, Alaska

How to reduce wound dehiscence in obese gravidas

Congratulations on the excellent articles on obesity in pregnancy. When it comes to closing the abdominal wound in extremely obese women who require cesarean delivery, I suggest retention sutures of #5 (or #4) Mersilene, which I have used for more than 40 years.

I close the parietal peritoneum, then insert the sutures (without tying them) through the rectus abdominis, rectus fascia, subcutaneous fat, and skin. I then close each anatomic layer. After closing the skin, I tie each retention suture moderately tightly and apply a sterile dressing. I remove the staples on postop day 5 or 6 and the retention sutures 48 hours later.

I have never encountered wound dehiscence using this technique. (By the way, until 1982, I had to use heavy thread or nylon sutures.)

Peter M. Zablotsky, MD
Queens, NY

Look for vitamin D deficiency

Another deficiency to screen for in the obese gravida is vitamin D. Measurement of 25-OH vitamin D should be routine in this at-risk population.

John Lewis, MD
Waterbury, Conn

» Dr. Phillips and Dr. Henderson respond:

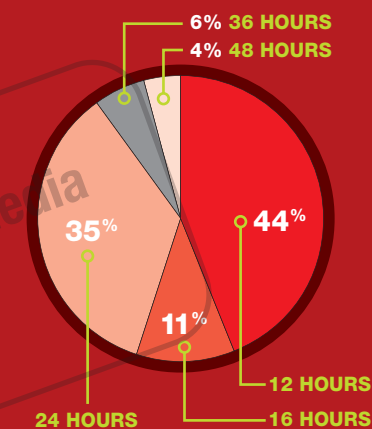
Dr. Worrall makes a good point. The fetal anomaly screen can be challenging

Instant Poll Results

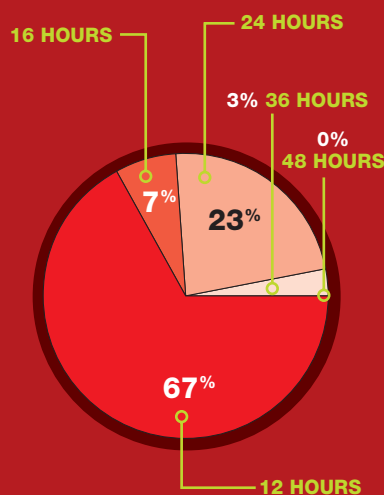


From January 2009

What do you think is the appropriate average duty-shift length for an ObGyn resident?



For an ObGyn attending?



Instant Poll → page 10

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to perform in the obese patient; waiting until after 20 weeks' gestation can help improve visualization. In some cases, however, adequate visualization may never be achieved, and some anatomy may be incompletely evaluated.

In a study in 1990, Wolfe and colleagues found complete ultrasonographic (US) visualization to be 14.5% lower in women who had a body mass index above 36.¹ Some have used transumbilical US (using a transvaginal probe) in an attempt to improve visualization.

Dr. Zablotsky's pearl is useful. We like to use a long-lasting absorbable monofilament suture, such as PDS, on the fascia for added support.

Dr. Lewis is correct that vitamin D is an important screen, especially in women who are vegetarian or who have minimal sun exposure.

Reference

1. Wolfe HM, Sokol RJ, Martier SM, Zador IE. Maternal obesity: a potential source of error in sonographic prenatal diagnosis. *Obstet Gynecol.* 1990;76:339-343.

“WHAT'S THE GIST OF A NEW FDA LABEL FOR THE LNG-IUS?”

ANITA L. NELSON, MD, AND RAQUEL ARIAS, MD (FEBRUARY 2009)

Is LNG-IUS advisable for young adolescents?

Dr. Nelson and Dr. Arias did not mention the recent trend among some parents of requesting the levonorgestrel-releasing intrauterine system (LNG-IUS) for their young teenage daughters. I would appreciate their comments on use of this system in adolescents up to 18 years old. In my opinion, this group is at high risk of having multiple partners (who themselves have multiple partners) and, therefore, is more likely to contract a sexually transmitted disease (STD).

A recent report from the CDC revealed that, among women 15 to 25 years old, only 6.8% were tested for *Chlamydia trachomatis* during a

routine visit.¹ That percentage rose to 16% during a preventive visit, and to 23% during a visit for Pap testing. Clearly, most teenagers and young adults are not being tested at all.

What is the evidence for or against the LNG-IUS in this age group as it relates to pelvic infection?

Aly A.M. Gorrafa, MD, MS
Welch, WV

Reference

1. Hoover K, Tao G, Kent C. Low rates of both asymptomatic chlamydia screening and diagnostic testing of women in US outpatient clinics. *Obstet Gynecol.* 2008;112:891-898.

>> Dr. Nelson and Dr. Arias respond:

It is laudable that the parents are involved and want their children to have accurate information about their contraceptive options, but requests for contraception should be made by the adolescent women themselves. The most effective methods for sexually active women are the IUD and implant.

Dr. Gorrafa's question about LNG-IUS use among teens is important. Nulliparity has never been a contraindication to IUD use in the United States. The IUD will not cause STD-related pelvic inflammatory disease or infertility. In their classic study, Hubacher et al found no increase in infertility among nulliparous women who used the copper IUD, compared with nonusers.¹ However, infertility was associated with antibodies to Chlamydia trachomatis.

The point about inadequate screening of teens is well taken but should not preclude IUD use. The IUD does not cause the STD or increase the risk that a sexually transmitted cervical infection will ascend into the upper genital tract. Nor is it necessary to remove the IUD to treat salpingitis.

Reference

1. Hubacher D, Lara-Ricalde R, Taylor DJ, Guerra-Infante F, Guzmán-Rodríguez R. Use of copper intrauterine devices and the risk of tubal infertility among nulligravid women. *N Engl J Med.* 2001;345:561-567.

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