"HOW DID WE ARRIVE AT A WORLD-WIDE EPIDEMIC OF VITAMIN D DEFICIENCY?"
ROBERT L. BARBIERI, MD
(EDITORIAL; JUNE 2010)

Vitamin D is vital for the developing fetus

I appreciated Dr. Barbieri's editorial on vitamin D deficiency. Most obstetricians do not realize the consequences of vitamin D deficiency for the developing fetus and newborn. The maternal vitamin D level has an effect on fetal acquisition of bone mineral in utero.

Mother–offspring cohort studies have shown that vitamin D insufficiency has a detrimental effect on bone mineral accrual by the fetus, leading to reduced bone mass at birth and in childhood.[1] Vitamin D deficiency can cause growth retardation and skeletal deformities and may increase the risk of hip fracture in later life.[2]

Childhood rickets has reemerged due to vitamin D deficiency in mothers during pregnancy. Fetal stores of vitamin D depend entirely on maternal supply. Most prenatal vitamins contain only 400 IU of vitamin D daily. This amount may not be sufficient for both mother and developing fetus.

Milk from breastfeeding mothers provides little vitamin D. Women who are deficient in this nutrient provide even less.

Vitamin D also plays an important role in glucose metabolism. Vitamin D deficiency increases insulin resistance and decreases insulin production.[2] Increasing the intake of vitamin D during pregnancy reduces the development of islet antibodies in the offspring, which may, in turn, reduce the incidence of diabetes in the offspring.[3] One study demonstrated that a daily intake of 1,200 mg of calcium and 800 IU of vitamin

JUNE 2010

D lowered the risk of type 2 diabetes in women by 33%.[4]

When ordering a prenatal blood test profile, it is important to include assessment of 25-hydroxyvitamin D to determine which patients require supplementation to prevent detrimental fetal effects.

Frank Bonura, MD
Director, Department of ObGyn
and Osteoporosis Program
St. Catherine of Siena Medical Center
Smithtown, NY

References
1. Javaid MK, Crozier SR, Harvey NC, et al, for Princess Anne Hospital Study Group. Maternal vitamin D status during pregnancy and childhood bone mass at age 9 years: a longitudinal study. Lancet. 2006;367(9504):36–43.
2. Holick MF. Vitamin D deficiency. N Engl J Med. 2007;357(3):266–281.
3. Hyppönen E, Läärä E, Reunanen A, Järvelin MR, Virtanen SM. Intake of vitamin D and risk of type 1 diabetes: a birth-cohort study. Lancet. 2001;358(9292):1500–1503.
4. Pittas AG , Dawson-Hughes B, Li T, et al. Vitamin D and calcium intake in relation to type 2 diabetes in women. Diabetes Care. 2006;29(3):650–656.

›› Dr. Barbieri responds:

Measure the maternal vitamin D level

I wholeheartedly agree with Dr. Bonura's important advice. As obstetricians, we can improve the health of the mother and newborn by measuring maternal 25-hydroxyvitamin D levels and prescribing adequate amounts of vitamin D.

Who would have thought that vitamin deficiency would be a continuing public health problem in 2010?

"CAN WE REDUCE THE RATE OF SCHEDULED BIRTHS THAT OCCUR EARLIER THAN 39 WEEKS OF GESTATION?"
GEORGE A. MACONES, MD
(EXAMINING THE EVIDENCE; JUNE 2010)

Early scheduled births are fueled, in part, by complacency and greed

Yes, we can increase the number of births that occur closer to term, but it will take time and effort.

First, we must address and dispel a few myths. Not long ago, even maternal-fetal medicine specialists, who should know better, stopped trying to prolong pregnancies beyond 32 weeks. Their attitude was: "That baby will survive—why bother?"

Second, NICUs generate handsome revenue by caring for preemies—and many hospitals have taken notice!

I put myself in hot water with hospitals and a colleague by promoting term deliveries. We really need to consider our responsibility to surpass "do no harm." Rather, we need to ask: "Are we helping our patients—or just ourselves?"

Stefan Semchyshyn, MD, MBA
Jonesborough, Tenn

"New culture" of obstetrics isn't so great

There has been a great outcry to reduce cesarean births (for good reason, to my mind). I believe that a significant number of early scheduled births have contributed to the rise in the rate of cesarean delivery. I believe that we are experiencing a "new culture" of obstetrics: "I can do

CONTINUED ON PAGE 15

it, therefore, I will." God forbid that an OB should wait until the patient goes into labor and he or she has to get up in the middle of the night to take care of her.

Robert S. Ellison, MD
W. Covina, Calif

"YOU SAY YOU WANT A REVOLUTION. WELL..."
CHARLES E. MILLER, MD
(JULY 2010)

Gynecologic surgeons need more than a curriculum

Dr. Miller expresses my sentiments exactly when he laments the reluctance of gynecologists to adopt minimally invasive therapies. I am a proud minimally invasive surgeon, and I have wholeheartedly adopted minimally invasive techniques.

However, Dr. Miller misses the most important point when he proposes that the solution to the problem of under utilization of minimally invasive gynecologic surgery (MIGS) is an advanced curriculum for laparoscopy for our residents.

Clearly, it's true that our residents need better training in MIGS, but a better curriculum would barely begin to solve the problem. The problem is that our specialty has advanced surgically to a point where a 4-year residency program—focusing on two mostly separate fields of obstetrics and gynecology—is seriously inadequate time to learn the advanced skills that a modern gynecologist needs.

To be a minimally invasive surgeon, you need more cases, more time, more training. To understand pelvic floor anatomy and urinary tract disorders, you need more time, more cases, more training. It is simply impossible to accomplish this in a 4-year ObGyn residency.

Our field is at least as complicated as other surgical subspecialties, virtually all of which require at least 5 years of training. But a gynecologist essentially gets only 2 years! I agree that we need a curriculum, but our residents simply can't gain the experience necessary to be a 21st century gynecologist in the time we give them.

We need to seriously rethink how we train ObGyns. Then, we may be able to bring our field into the MIGS "revolution."

Saul Weinreb, MD
Director, Minimally Invasive Gynecologic Surgical Training
Franklin Square Hospital
Baltimore, Md

›› **Dr. Miller responds:**

Postgraduate training can enhance adoption of minimally invasive techniques

I appreciate Dr. Weinreb's comments on how to encourage gynecologists to adopt minimally invasive surgery. I agree that it is difficult to advance a curriculum in MIGS when ObGyn residencies provide only 24 months of training in gynecology. Nevertheless, I do believe that if we can provide our residents with a well-thought-out curriculum in operative laparoscopy and hysteroscopy, they will adopt these modalities after training. Such a curriculum should involve not only didactic lectures, but work in a skills lab and mentored surgery.

I have long stated the importance of postgraduate training. The AAGL/ASRM Fellowship in MIGS that I mentioned in my commentary has proved to be an excellent way for young physicians to hone their skills. Many program graduates have gone on to faculty positions teaching operative laparoscopy and hysteroscopy and become busy minimally invasive gynecologic surgeons in private practice.