

Managed Properly, Postbariatric Pregnancy Is Safe

BY KATE JOHNSON
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Women who become pregnant after bariatric surgery should experience fewer complications and adverse outcomes than if they had remained obese if managed appropriately, according to experts.

"There's more risk for obese patients who become pregnant than for pregnant patients who've had bariatric surgery and lost weight," said Dr. Jacques S. Abramowicz, codirector of the fetal and neonatal medicine program, professor of obstetrics and gynecology, and director of ob.gyn. ultrasound at Rush University Medical Center in Chicago.

"Once women have had the bariatric surgery, as long as they make an effort to wait the recommended year before getting pregnant, we are more than happy to take care of them," agreed Dr. Laura Riley, director of labor and delivery at Massachusetts General Hospital and a high-risk obstetrician.

Dr. Riley chaired the committee that wrote the American College of Obstetricians and Gynecologists Committee Opinion (#315) on Obesity in Pregnancy in 2005. It recommends that women wait 12-18 months after bariatric surgery before conceiving to allow time for weight loss and postsurgical adjustment, she said in an interview (see box).

"I do a fair number of prepregnancy consultations, and I've seen many women

who at 6 months after bariatric surgery are not ready to become pregnant because they haven't yet gotten the full effect of the surgery, so their obesity-related risks are essentially the same as before the surgery," Dr. Riley said.

Also, it takes time to figure out which foods and how much of them they can eat. "It's important to allow time for surgical healing," she said.

Nutritional issues are acute in the early postsurgical phase, but this risk is never eliminated entirely, Dr. Abramowicz said in an interview: "Both malabsorptive and restrictive bariatric surgery can cause deficiencies in folic acid, iron, vitamin B₁₂, and calcium—so supplementation and nutritional counseling are important." The greatest risk lies with unintended pregnancies, he said. "If it's a planned pregnancy, [the women] can take supplements from the start, but what happens often, if they are not warned, is that—because they lose so much weight—their fertility returns unexpectedly, and they become pregnant but do not realize it because they are used to irregular cycles."

At least one study suggests "patient and physician anxiety over poor outcome of pregnancy during the first year can be allayed" (Am. J. Surg. 2006;192:762-6). A retrospective review of 21 pregnancies conceived within 1 year of bariatric surgery and 13 conceived after 1 year found "no significant episodes of malnutrition, adverse fetal outcomes, or intrauterine growth retardation" in either

group. However, compared with the group that conceived later, patients in the early group did have a significantly higher miscarriage rate (24% vs. 0%), which was also higher than the 15%-20% incidence seen in the general population, noted Dr. Tuoc N. Dao and colleagues from the department of surgery at Baylor University Medical Center in Dallas.

Studies on post-bariatric surgery pregnancies are sparse in the obstetric literature, but in one comparison of all pregnancies with (298) and without (158,912) a history of bariatric surgery between 1998 and 2002 at Soroka University Medical Center, Beer-Sheva, Israel, Dr. Eyal Sheiner and colleagues found no association between the surgery and adverse perinatal outcomes (Am. J. Obstet. Gynecol. 2004;190:1335-40).

Dr. Abramowicz participated in a subsequent study with Dr. Sheiner, which included pregnancies with gestational diabetes from the first study, comparing 28 pregnancies with a history of bariatric surgery with 7,986 pregnancies without such a history. "Perinatal outcome was comparable between the groups, and no significant differences were noted with regard to complications such as perinatal mortality, congenital malformations, and low Apgar scores at 1 and 5 minutes," they wrote (Am. J. Obstet. Gynecol. 2006;194:431-5).

A government report released in January shows a ninefold increase from 1998 to 2004 in the number of bariatric surgeries

performed in the United States (from 13,386 to 121,055). "We're doing a better job of making women aware of the extreme pregnancy complications if they are obese—and they are turning to bariatric surgery more than they did in the past," said Dr. Riley. ■

Four Points to Reinforce

The ACOG Committee Opinion #315 on Obesity in Pregnancy recommends that women who have undergone bariatric surgery require the following counseling before and during pregnancy:

- ▶ Patients with adjustable gastric banding should be advised that they are at risk of becoming pregnant unexpectedly after weight loss following surgery.
- ▶ All patients are advised to delay pregnancy for 12-18 months after surgery to avoid pregnancy during the rapid weight-loss phase.
- ▶ Women with a gastric band should be monitored by their general surgeons during pregnancy because adjustment of the band may be necessary.
- ▶ Patients should be evaluated for nutritional deficiencies and vitamin supplementation when necessary.

Prepregnancy BMI and Gestational Weight Predict Fetal Macrosomia

BY DIANA MAHONEY
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SAN FRANCISCO — Prepregnancy body mass index and gestational weight gain are more predictive of fetal macrosomia than homeostasis model assessment and glucose load, a study has shown.

Because both of these are modifiable risk factors, "they should be emphasized in order to minimize the risk of macrosomia and associated adverse outcomes," reported Dr. Chloe A. Zera in a poster presentation at the annual meeting of the Society for Maternal-Fetal Medicine.

In a prospective study designed to investigate whether either early or late gestational insulin resistance predicts infant birth weight and risk of macrosomia-related cesarean delivery, Dr. Zera of Boston's Brigham and Women's Hospital and colleagues collected homeostasis model assessment (HOMA) data, glucose load test (GLT) results, and clinical information including prepregnant body mass index (BMI), gestational weight gain, maternal age, delivery information, and infant birth weight for 439 pregnant women enrolled in the Massachusetts General Hospital Obstetrical Maternal Study.

All of the women had fasting blood samples drawn at 16-18 weeks gestation and all

had GLT performed as part of routine care. Prepregnancy BMI was based on weight at first prenatal visit.

The investigators used multivariate analysis to predict infant birth weight as a function of the baseline characteristics of the study population and logistic regression to predict the odds of macrosomia and cesarean section, said Dr. Zera.

An analysis showed that 37% of the women in the study were overweight or obese prior to pregnancy, 17% of the infants in the cohort were macrosomic (more than 4,000 g), 27% of the deliveries were by cesarean section, and 30% of the cesarean deliveries were for macrosomia or failure to progress, Dr. Zera reported.

In the multivariate linear regression analysis, total gestational weight gain, prepregnancy BMI, and maternal age were significant predictors of birth weight, Dr. Zera said, noting that neither HOMA nor GLT were predictive. Both total weight gain and maternal BMI were significantly associated with risk of macrosomia in the logistical regression model, and maternal BMI alone was significantly associated with risk of cesarean section for macrosomia, she said.

Reducing prepregnancy BMI and decreasing gestational weight gain may reduce the risk of macrosomia and subsequent cesarean delivery, Dr. Zera noted. ■

Most Pediatric Labial Agglutination Will Resolve Without Treatment

HOUSTON — Labial agglutination resolves spontaneously at puberty in up to 80% of girls and has a 40% recurrence rate after treatment, whether medical or surgical, making nontreatment the best option when patients are asymptomatic, according to Dr. Abbey B. Berenson, professor of obstetrics and gynecology at the University of Texas at Galveston.

"There is only one case report of this leading to urinary retention," she said at a conference on vulvovaginal diseases jointly sponsored by Baylor College of Medicine and the Methodist Hospital.

Extensive labial agglutination is present in 5% of prepubertal girls and up to 10% of girls aged 12 months or under, she said. Patients are usually referred with the chief complaint of "absent vagina" because there may be only a small opening visible below the clitoris.

Although the majority of patients are asymptomatic, some may have urinary symptoms. "The vagina can form a

sort of pocket in which urine gathers and then dribbles out. These are the ones you want to treat because you don't want to see kidney damage due to repeat urinary tract infections or urethritis," she said.

Dr. Berenson recommends topical estrogen cream as first-line treatment.

"This works for thin adhesions but not thick or recurrent ones." Parents should be instructed to use a finger to apply the estrogen cream over the gray fusion line using some pressure. This should be done twice a day for 2-4 weeks but stopped if breast budding occurs.

The risk of recurrence can be lowered with good hygiene and reduced irritation, because the condition is believed to develop as a result of low estrogen levels and local irritation, which injures tissue and results in adherence of the labia minora.

Surgical treatment should be reserved for those who fail medical therapy, Dr. Berenson said.

—Kate Johnson



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