

CLINICAL CAPSULES

Morbid Obesity Complicates Intubation

Despite attempts at optimal positioning, it's significantly more difficult to intubate patients who are morbidly obese than those of normal weight, according to a poster presentation by Dr. Thomas C. Mort at the annual congress of the Society of Critical Care Medicine.

In a retrospective analysis of more than 1,200 patients, 72% of patients with body mass indexes below 25 kg/m² could be intubated on the first try, compared with just 52% of those with BMIs greater than 40. At least three attempts were required for 18% of the morbidly obese (MO) patients, compared with 10.5% of the normal-weight patients.

Accessory airway devices were required far more often in MO patients. Of MO patients, 58% required one of these devices, compared with 22% of normal-weight patients. Bougies were required 21% of the time in MO patients, compared with 10% of normal-weight patients. Similarly significant differences were noted for laryngeal mask airways (28% vs. 4%), but no significant differences were noted in the use of fiberoptic bronchoscopes or Combitubes.

The study involved 1,253 consecutive emergency intubations over a 12-year period from 1994 to 2005. Dr. Mort, of Hartford (Conn.) Hospital, isolated those cases in which emergency airway management took place outside the operating room. Fourteen percent of the cohort (174 patients) had BMIs greater than 40, and they were compared with a cohort of normal-weight patients.

Mild hypoxemia was found in 33% of the MO group, significantly greater than the 17% of the normal-weight patients. Likewise, severe hypoxemia was more common among MO patients (11% vs. 2%).

Birth Control and Weight Gain

Use of depot medroxyprogesterone acetate was associated with increasing weight gain in obese girls during an 18-month prospective study, reported Dr. Andrea E. Bonny of Case Western Reserve University, Cleveland.

Of 450 girls aged 12-18 years, most of whom were using hormonal contraception for the first time, 26% chose depot medroxyprogesterone acetate (DMPA), 39% chose oral contraceptives (OCs), and 36% acted as controls. The subjects attended one of four urban clinics; more than 62% were black (Arch. Pediatr. Adolesc. Med. 2006;160:40-5).

At baseline, obesity was significantly more prevalent in OC users (29%), compared with DMPA users (13%) and controls (18%), Dr. Bonny and her associates said.

Girls who were obese before starting DMPA (13%) showed significantly greater weight gain than did obese controls or girls who were obese when they started taking OCs. After adjustment for race, gynecologic age (subject's age minus age at menarche), and previous pregnancy, the mean weight change in obese DMPA users was 9.4 kg, compared with 4.0 kg in nonobese DMPA users.

For OC users, the mean weight gain was 0.2 kg in obese subjects versus 2.8 kg in nonobese subjects. "For nonobese subjects, contraceptive method was not significantly associated with weight," they said.

Obesity and IUI Outcomes

Obese, ovulatory women can achieve similar pregnancy rates with intrauterine insemination, compared with women of normal weight, but obese women require higher doses of gonadotropins for adequate ovarian stimulation, according to Dr. William C. Dodson of Pennsylvania State University in Hershey.

In a study presented at the joint annual meeting of the American Society for Reproductive Medicine and the Canadian Fertility and Andrology Society, Dr. Dodson evaluated the effect of obesity on su-

perovulation and intrauterine insemination (IUI) outcomes among 333 ovulatory women who had been infertile for a mean of 3.2 years.

A total of 206 of the women (62%) were of normal weight (18.5-25 kg/m²), 16 (5%) were underweight (less than 18.5 kg/m²); 68 women (20%) were overweight (25-30 kg/m²), and 43 (13%) were obese (more than 30 kg/m²).

Of these women, 35% had idiopathic infertility, 31% had endometriosis, and 22% had various diagnoses, including pelvic adhesions, unilateral tubal occlusions, and leiomyomata. After adjustment for age, year of treatment, and the use of go-

nadotropin-releasing hormone agonists or antagonists, there were no significant differences in pregnancy rates between the women, regardless of BMI.

This trend was observed for pregnancy rates on the first cycle of IUI (which ranged from 6% to 15%), as well over all 814 treatment cycles (which ranged from 11% to 16%).

In addition, the number of large preovulatory follicles (measuring at least 17 mm) did not differ significantly between the different BMI categories (3.3 to 3.9). However, total gonadotropin dose was higher for obese women.

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