Clinical Capsules

Rupture Risk Up With Single Closure

Single-layer closure from a prior cesarean delivery increases risk of symptomatic uterine rupture in a subsequent trial of labor, compared with double-layer closure, Dr. Martine Goyet said at the annual meeting of the Society for Maternal-Fetal Medicine. Dr. Goyet and colleagues conducted a multicenter, case-control study to compare the two closure techniques. They reviewed records from 1993 to 2003 for nine maternity wards. "Single-layer closure was the only significant negative factor associated with uterine rupture in a multivariate analysis [odds ratio 2.31]," said Dr. Goyet of the department of obstetrics and gynecology, Hôpital Sainte-Justine, Montreal. "Prior vaginal delivery was the only positive significant factor [OR 0.49]." They identified 96 cases of symptomatic uterine rupture, including emergency laparotomy, using ICD-9 codes and perinatal databases. They also identified three matched controls for each case. The controls were women who underwent a trial of labor before each uterine rupture case; the control group totaled 288. Maternal age and parity did not significantly differ between groups. Cases had a history of one low-transverse cesarean delivery and uterine rupture with an attempted trial of labor. The researchers excluded women with a history of more than one cesarean delivery, prior myomectomy, or multiple gestations. Women who had uterine rupture were more likely to have had a single-layer closure than controls (37% vs. 20%); induction of labor with an unfavorable cervix (38% vs. 23%); gestational age of 41 weeks or more (26% vs. 17%); birth weight of 4,000 g or greater (23% vs. 13%); and no prior vaginal delivery (87% vs. 73%), according to a univariate analysis. Women who had uterine rupture also tended to have a shorter interval between deliveries (less than 24 months), Dr. Goyet said.

Herpes Hepatitis Diagnosis Lifesaving

The diagnosis of herpes simplex hepatitis in pregnancy is one that can't afford to be missed, Dr. Eileen Hay said at the annual meeting of the American College of Gastroenterology. That's because treatment with acyclovir or vidarabine is lifesaving—and without it, one-half of affected mothers will die of fulminant hepatitis, stressed Dr. Hay, professor of medicine at the Mayo Medical School, Rochester, Minn. Herpes hepatitis is a rare disorder. In pregnancy, it occurs in the third trimester. It is usually but not always preceded by a flulike viral prodrome. The typical mucocutaneous herpetic lesions aren't always present. The characteristic features of this infection are the third-trimester presentation, marked elevation of transaminases (with levels often in the thousands) along with coagulopathy and encephalopathy, and no jaundice. Liver biopsy shows hepatocytes with the classic viral inclusion bodies of herpes simplex virus. It's necessary to consider delivery only in the very rare instance where the patient shows no response to antiviral therapy, Dr. Hay said.

Smoking Boosts Pelvic Prolapse Risk

Tobacco smoking is an independent risk factor for pelvic organ prolapse, data from the Pelvic Organ Support Study suggest. The findings from this multicenter, cross-sectional, observational study—known as POSST—contrast with those from the Women's Health Initiative, which suggested that smoking was protective against pelvic organ prolapse, Dr. Cecilia K. Wieslander reported at the annual meeting of the American Urogynecologic Society. Of 906 women included in the POSST analysis, 773 were nonsmokers (including 173 former smokers) and 133 were current smokers. On multivariate analysis, smoking was an independent, noninteractive risk factor for pelvic organ prolapse of stage II or greater (odds ratio 2.37), said Dr. Wieslander, a fellow in obstetrics and gynecology at the University of Texas Southwestern Medical Center at Dallas. Even among nulliparous smokers, the prevalence of prolapse was significantly greater, compared with the prevalence in nonsmokers (28% vs. 12%, adjusted odds ratio 1.95). In nonsmokers with one vaginal delivery, the prevalence of prolapse increased from 12% to 27%, so the risk associated with smoking in nulliparous women is greater than the risk associated with one vaginal delivery in nonsmokers. The findings, which are consistent with laboratory data showing that smoking-induced activation of vaginal macrophage elastase may contribute to the pathogenesis of organ prolapse, suggest that smoking is a modifiable risk factor for pelvic organ prolapse. However, further study of dose response is needed to evaluate the effects of secondhand smoke exposures, to determine if symptoms associated with smoking—such as chronic cough—are a cause of pelvic organ prolapse, and to determine if other illnesses with effects similar to those of smoking—such as inflammation—can contribute to pelvic organ prolapse, Dr. Wieslander said.

—From staff reports

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The face of migraine—the life your patients may be missing

Migraine impacts family

Consider Karen, a 33-year-old mother with 2 young children. Although she only gets about 2 migraines a month, the disruption she endures keeps her from the things that are most important to her. A migraine recently prevented her from attending her daughter's preschool graduation. Another attack caused her to miss her son's little league baseball game. Karen is tired of missing out because of migraine.

Migraine impacts work

Now imagine Elena, a talented young designer who experiences at least 3 migraines a month. When asked how her migraines affect her daily routine, she admits that she can't concentrate at work during a migraine—a recent attack kept her from an important meeting with a client. Despite the fact that she has tried 2 different triptans, she just can't be at her best when she has a migraine. Elena is concerned how her career could be affected.

What treatment would you recommend for these patients?

Conservative estimates indicate 40% of migraine sufferers meet the criteria for prevention.[2]

Migraine prevention can help make a difference

Conservative estimates indicate 40% of migraine sufferers meet the criteria for prevention and the need may be as high as 60%.[2,6] Preventive therapy could help reduce migraine frequency by 50%, on average. It can also help reduce the severity and duration of migraines that do occur.[3] Yet migraine prevention is underutilized and many migraine sufferers are not offered prevention as part of their treatment regimen.[3]

Many more migraine patients could benefit from prevention than are currently receiving it.

Study Investigators: Richard B. Lipton, Stephen D. Silberstein, Merle Diamond, Frederick G. Freitag, Marcelo Bigal, Walter F. Stewart, Michael L. Reed, Seymour Diamond; Elizabeth Loder.[1,7]

*A validated, self-administered headache questionnaire was mailed to a representative sample of US households in 2004. Migraine cases were identified using ICDH-2 symptom criteria for migraine with and without aura. Cases reporting at least 1 severe headache in the past year were included; cases with daily (28+ per month) headaches were excluded.

*With support from Ortho-McNeil Neurologics, Inc.

References: 1. Lipton RB, Diamond M, Freitag FG, Bigal M, Stewart WF, Reed ML. Migraine prevention patterns in a community sample: results from the American Migraine Prevalence and Prevention (AMPP) study [abstract]. Mount Royal, NJ: American Headache Society; March 24, 2005. **2.** Lipton RB, Diamond M, Freitag FG, Bigal M, Stewart WF, Reed ML. Migraine prevention patterns in a community sample: results from the American Migraine Prevalence and Prevention (AMPP) study. Poster presented at: American Headache Society 47th Annual Scientific Meeting; June 23-26, 2005; Philadelphia, Pa. **3.** National Headache Foundation Web site. American Migraine Prevalence and Prevention (AMPP) study fact sheet. Available at: http://www.headaches.org/consumer/AMPP/AMPPFactSheet.pdf. Accessed July 28, 2005. **4.** Ramadan NM, Silberstein SD, Freitag FG, Gilbert TT, Frishberg BM, and the US Headache Consortium. Evidence-based guidelines for migraine headache in the primary care setting: pharmacological management for prevention of migraine. American Academy of Neurology. US Headache Consortium. 2000:1-55. **5.** Snow V, Weiss K, Wall EM, Mottur-Pilson C, for the American Academy of Family Physicians and the American College of Physicians–American Society of Internal Medicine. Pharmacologic management of acute attacks of migraine and prevention of migraine headache. *Ann Intern Med.* 2002;137:840-849. **6.** Data on file. Ortho-McNeil Neurologics, Inc. **7.** Silberstein S, Diamond S, Loder E, Reed ML, Lipton RB. Prevalence of migraine sufferers who are candidates for preventive therapy: results from the American Migraine Prevalence and Prevention (AMPP) study [abstract]. Mount Royal, NJ: American Headache Society; March 24, 2005.

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