likely to receive public insurance than are white women and thus are subject to receiving their contraception by a provider-in-training. The negative family planning experiences of these women may contribute to already existing conspiracy beliefs regarding the decreased safety and efficacy of contraceptive methods in the African American community. Although we found this study valuable, the message from a social justice perspective is negative, namely that African American women and those with Medicare and Medicaid may be subject to suboptimal care regarding IUD insertion.

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Penina Segall-Gutierrez, MD, MSc
Mellisa Natavio, MD, MPH
Tania Basu, MD
Jessica Atrio, MD
Keck School of Medicine, University of Southern California, Los Angeles, California

REFERENCES

In Reply:
We appreciate the comments by Drs. Segall-Gutierrez, Natavio, Basu, and Atrio about our article regarding different rates of intrauterine device (IUD) malpositioning by race and insurance status. Although the authors suggest that our study demonstrated increased rates of IUD malpositioning among African American women, this association did not persist in our multivariate analysis, whereas the association between insurance status and malpositioning did persist. This suggests that race alone is not a risk factor for malpositioning when controlling for insurance status. We wholeheartedly agree that the increased rate of IUD malpositioning among women with public or no insurance is unlikely biological and more likely related to a higher incidence of IUD insertion by trainees among this population. We are also aware of the literature that suggests higher rates of IUD complications when inserted by trainees, and we support increased educational efforts to improve patient safety.

Financial Disclosure: The authors did not report any potential conflicts of interest.

Kari P. Braaten, MD, MPH
Alisa B. Goldberg, MD, MPH
Department of Obstetrics, Gynecology and Reproductive Biology, Brigham and Women’s Hospital, Boston, Massachusetts

REFERENCES

Neonatal Outcomes After Implementation of Guidelines Limiting Elective Delivery Before 39 Weeks of Gestation

To the Editor:
Ehrenthal et al report a reduction in neonatal intensive care unit admissions but an increase in incidences of birth weight more than 4,000 g and stillbirths (before 39 weeks of gestation) after the implementation of a policy proscribing nonindicated delivery before 39 weeks. The stillbirth finding should be interpreted cautiously for several reasons. First, results for other outcomes, but not for stillbirth, were adjusted for differences in characteristics, including ethnicity and medical comorbidities. Although the small number of stillbirths limited the ability to adjust, differences in baseline characteristics could explain the difference in stillbirth rates. Second, the policy was associated with a nonsignificant increase in total stillbirths (unadjusted relative risk 2.14, 95% confidence interval 0.87–5.26). However, when the authors stratified by gestational age, there was a 3.6-fold increase in stillbirths at 37–38 weeks. Such stratification is exploratory and increases the likelihood of observing a chance association. A test of interaction is indicated to explore whether the findings by gestational-age subgroups are truly different. Moreover, one fewer stillbirth after introduction of the policy would render the comparison of stillbirths before 39 weeks nonsignificant. Third, policies to reduce deliveries before 39 weeks of gestation specifically target women without indications for early delivery. Therefore, women with comorbidities associated with an increased risk of stillbirth could be excluded (or analyzed separately). Finally and most importantly, comparative data on neonatal deaths are crucial to interpreting stillbirths. Some reports suggest that neonatal deaths are decreased at 39–40 weeks as compared with delivery at 37–38 weeks. The study’s findings certainly underscore the need to thoroughly monitor the effect of initiatives to prevent nonindicated delivery before 39 weeks of gestation but should not deter us from pursuing this goal.

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Alan T. N. Tita, MD, PhD
John Owen, MD, MSPH
University of Alabama at Birmingham, Birmingham, Alabama

REFERENCES

In Reply:
We agree with Tita and Owen that our findings could be the result of unrelated changes in the obstetric...
population or health services, and the assumption of a causal relationship with the implementation of the guidelines should be viewed with caution. The authors do raise two important points that are worthy of further discussion. First, the guidelines apply only to elective deliveries and, therefore, it could be argued that women with comorbidities should be analyzed as a separate group. This examination would require data from a large population, and we agree that such a study clearly is needed. In addition, the authors point out that it is the balance between the risk of stillbirth and the benefits in neonatal outcomes, including neonatal mortality, that must be weighed. Again we agree, and, to this end, encourage the monitoring of fetal and neonatal outcomes for large and diverse populations, regions, and institutions. This will enable the effectiveness of the guidelines at achieving the goals of improved perinatal outcomes to be established.

Financial Disclosure: The authors did not report any potential conflicts of interest.

Deborah B. Ehrenthal, MD, MPH
Matthew Hoffman, MD, MPH
Gordon Ostrum Jr, MD
Department of Obstetrics and Gynecology, Christiana Care Health System, Newark, DE

REFERENCE

Lethal Fetal Anomalies: Why the Big Void?

To the Editor:

I read with interest the article by Kovac, “Lethal Fetal Anomalies: Why the Big Void?” in which profound and timely issues are raised. When a lethal-type fetal anomaly is identified in the prenatal period by ultrasonography or other techniques, the results can be devastating to the patient and her family. However, termination of the pregnancy is not the only choice. When the diagnosis of a lethal anomaly is confirmed, it is an opportunity to discuss various options for management. We believe one of those options, which was not explored by Kovac, is for perinatal palliative care.

The World Health Organization defines palliative care as an approach that improves the quality of life of patients and their families who face life-threatening illnesses or disease. Palliative care provides relief of pain and affirms that life and dying are both part of a natural process. Perinatal palliative care incorporates a team approach to help patients and their families when severe fetal anomalies are identified. A comprehensive birth plan is developed that respects the life and dignity of the fetus and the wishes of the patient and her family. Supportive care is provided throughout the pregnancy and after delivery for the fetus (newborn), the patient, and the family. Patients still can choose to terminate the pregnancy, even with involvement of a perinatal palliative care team. However, some patients are not able or willing to terminate because of financial considerations, gestational age at the time of diagnosis, or personal beliefs and wishes.

Numerous organizations have established perinatal palliative care and hospice programs. We have initiated one at our institution, and the results have been most gratifying. This may not be the approach selected by everyone, but we believe it should be an important aspect to any hospital or practice that cares for pregnant patients whose fetuses have severe or lethal anomalies. A perinatal palliative care approach will provide optimal care for patients during difficult times.

Financial Disclosure: The author did not report any potential conflicts of interest.

Dana P. Damron, MD
Billings Clinic, Billings, Montana

REFERENCE

In Reply:

I appreciate the opportunity to respond to the letter sent by Dr. Damron regarding my Personal Perspectives article on lethal fetal anomalies.1 I appreciate Dr. Damron’s point that palliative care and perinatal hospice are available for patients who choose to continue the pregnancy when a lethal fetal anomaly is found. I am very familiar with this concept and understand that, regardless of the ultimate outcome, during the pregnancy and whatever time the newborn survives after the delivery is time the patient has with her child. This is often precious time she has to bond with and care for her child and to prepare to say goodbye. I do whatever I can to make this time as special for the families as possible and coordinate with our neonatal intensive care unit to provide the care and support or comfort measures that may be necessary at the time of delivery. This is a difficult time in these families’ lives, and there is a lot we can do to help them through it. I have heard of patients being told they should terminate or not getting the support they need for their decisions; fortunately, however, the centers where I have worked have been very good at supporting the patient’s decision to continue the pregnancy.

However, even by your own definition, palliative care for some of these patients may include termination of pregnancy because it will literally and figuratively lift the burden that they are carrying. The point I was bringing up in my article is that the patients who choose to terminate their pregnancies are faced with the additional challenge of lack of support for their decisions: care providers making them feel as if they are doing something wrong or being burdened with additional costs to follow through with a pregnancy termination. These patients do not come to their decisions lightly, and they still go through the same grief for their lost children. I believe that these patients deserve the same care, support, and compassion that patients who continue their pregnancies get, including coverage for their care.

Financial Disclosure: The author did not report any potential conflicts of interest.

Christine Kovac, MD
Perinatal Partners, Dayton, Ohio

REFERENCE