

Ob/Gyn Resident Research Abstracts

The Fifth Annual Northern California Kaiser Permanente (KP) Obstetrics and Gynecology (Ob/Gyn) Resident Research Symposium was held at the San Francisco Medical Center on April 21, 2007. The mission of this Research Symposium is to foster a spirit of scientific inquiry for KP Ob/Gyn residents and their faculty. Our goal is to familiarize residents with the research study techniques through first-hand experience in conducting research and presenting their findings. Our hope is that all who participate will find this academic pursuit invigorating and that a critical interest in research will be a cornerstone for their growth as Ob/Gyns.

David Levin, MD; David Walton, MD; and I, the three Ob/Gyn Residency Program Directors in KP, Northern California, have taken turns hosting this annual event. The quality of all the projects presented by our Chief Residents this year was exceptional. The following three abstracts will give you a flavor of the type of meaningful research our Ob/Gyn residents are performing.

— Robin Field, MD

Ob/Gyn Residency Program Director, Kaiser Permanente, San Francisco

Impact of Depression on Pregnancy in the Kaiser Permanente Santa Clara Medical Center.

Voedisch A, Brubaker K, Young M.

CONTEXT: Depression is a major leading health problem with a lifetime prevalence of 17% in the world's population. Women are twice as likely as men to suffer from depression and over 50% of cases occur during the reproductive years. As many as 20% of women suffer from depression during or after pregnancy and clinicians do a poor job of identifying those patients at risk. Depression during pregnancy leads to increased maternal health care costs by increasing office visits, somatic complaints, and hospital admissions. Those children born to depressed mothers often have impaired cognitive function, poor emotional adjustment, and an increased risk of suffering from a psychiatric disorder in their lifetime.

OBJECTIVE: Kaiser Permanente (KP) Santa Clara Medical Center recently instituted a screening and treatment program for women with depression during and after pregnancy. The purpose of this pilot study was to perform an initial evaluation of the efficacy of this screening program by identifying the

prevalence of depression both during and after pregnancy.

METHODS: A prescreening baseline rate of postpartum depression was determined through a chart review of all patients seen for a postpartum visit during a one-year period. The incidence of depression both during and after pregnancy was determined using standard screening tools.

RESULTS: The rate of postpartum depression before initiation of the screening program was 15%, 35% of whom were diagnosed and treated. The positive screen rate among all antepartum patients was 17%. Of those patients who were screened both antepartum and postpartum, 10% were positive antepartum and none of those patients developed postpartum depression. However, 10% of patients screened positive in the postpartum period and only 30% of those patients were treated for depression.

CONCLUSIONS: The rate of depression in pregnancy at KP Santa Clara Medical Center is similar to previously published data. The provider identification and treatment rates are also similar to published data. This pilot study demonstrates the need and validation of a screening program for depression during and after pregnancy.

Surgical Management of Grade 1 Endometrial Adenocarcinoma by Obstetrician-Gynecologists or Gynecologic Oncologists: A comparison of outcomes.

Rodriguez N, Tatman JL, Kato DT, Hung Y.

BACKGROUND: Endometrial cancer is the most common gynecologic malignancy in the US. Approximately 70% of endometrial cancers are stage I and carry greater than an 85% five-year survival rate. Despite this favorable prognosis, approximately 7400 women in this country will die from endometrial cancer during 2007, making it the eighth most common cause of cancer death in women. In August 2005, the American College of Obstetrics and Gynecology issued a practice bulletin recommending that most women with endometrial cancer should undergo systematic surgical staging, including pelvic washings, bilateral pelvic and para-aortic lymphadenectomy, and complete resection of all disease. Despite these recommendations, many obstetrician/gynecologists (Ob/Gyns) still continue to manage patients with grade I endometrial cancer. Currently there are no studies that investigate survival differences in patients with grade 1 endometrial cancer when managed by Ob/Gyns or gynecologic oncologists.

OBJECTIVE: To determine the survival rates in patients with preoperative grade I endometrial cancer when operated by obstetrician-gynecologists compared with gynecologic oncologists.

METHODS: A retrospective review of the Kaiser Permanente Northern California Cancer Registry for the 24-month period from 2000-2001 was conducted. All patients with preoperative biopsies demonstrating grade 1 endometrial cancer were included. Patients without preoperative biopsies, biopsies demonstrating complex hyperplasia or ≥ grade 2, and patients with other coexisting

primary malignancies were excluded. Analysis included age, race, comorbidities, surgical procedure, final grade, final stage, additional therapy, recurrences, and survival.

RESULTS: Of 621 patients with endometrial adenocarcinoma, 338 patients with a diagnosis of preoperative grade 1 endometrial cancer were identified: 336 patients underwent surgical management; 332 patients met inclusion criteria. Ob/Gyns operated on 200 patients; gynecologic oncologists operated on 132 patients. Patient demographics and comorbidities including tobacco use, obesity, hypertension and diabetes were similar between the two groups of surgeons. The recurrence rate for patients operated by Ob/Gyns was 4.5% compared to 6.8% when operated by gynecologic oncologists. The five-year overall survival rate was 88% versus 86% respectively. The five-year cancer-free survival rate was 97% versus 94%

CONCLUSIONS: Five-year survival rates for patients with grade 1 endometrial cancer are very favorable. This study did not show a significant difference in overall survival rates or cancer-free survival rates in patients with grade 1 endometrial cancer managed by Ob/Gyns compared with patients managed by gynecologic oncologists. Overall survival rates are more favorable when operated on by an Ob/Gyn generalist. Factors such as advanced

age and the presence of comorbidities such as diabetes and hypertension may influence overall survival rates.

Effects of Weight Gain on Neonatal Birth Weights and Cesarean Section Rates in Patients with Elevated BMI.

Lee, K

PURPOSE: The goals of this study were 1) to develop weight gain recommendations for patients with Body Mass Index (BMI) ≥ 25 with the lowest infant low-birth weight and macrosomia rates and 2) to review the effects of weight gain on maternal morbidity in patients with BMI ≥ 25 including the rates of cesarean section and operative deliveries.

MATERIALS AND METHODS: Data were collected from computerized prenatal and intrapartum charts on all term deliveries at Kaiser Permanente Santa Clara Medical Center from August 2004—August 2006. Pregravid BMI was calculated from height and weight measurements at early prenatal visits. Overweight and obese gravidas were included in the study. Exclusion criteria included: prenatal intake > 12.9 weeks, gestational or pre-existing diabetes, hypertensive disorders, excessive edema, and smoking/alcohol use. In order to delineate optimal weight gain in pregnancy, five different categories were as-

essed. Fetal outcomes included birth weight; maternal outcomes included cesarean and operative deliveries.

RESULTS: One thousand one hundred ninety-eight women met inclusion criteria on the basis of BMI ≥ 25 . Seven hundred ninety-nine gravidas met criteria for inclusion on the basis of the definition of overweight (BMI 25.0—29.9) and 399 gravidas met criteria on the basis of the definition of obese (BMI ≥ 30). Weight gain categories (≤ 10 lbs, 10.1-20 lbs, 20.1-30 lbs, 30.1-40 lbs, > 40 lbs) were assessed for all overweight and obese patients. The rates of small-for-gestational-age infants (< 2500 g) were not significant across weight gain categories. For the women gaining 10.1-20 lbs during pregnancy, the macrosomia rate was 2.7% in the overweight group and 10.7% in the obese group. Macrosomia rates (> 4000 g) increased with weight gain increments for both the overweight and obese categories, with up to a seven-fold increased risk in those gravidas gaining > 40 lbs. Increased weight gain was also associated with increased cesarean section rates.

DISCUSSION: This study provides data that the optimal weight gain for overweight and obese gravidas is ≤ 20 lbs. ❖

Preceding Discoveries

In our inquiries into any particular subject of medicine,
our labours will generally be shortened and directed to their proper objects,
by a knowledge of preceding discoveries.

— Warren J. *Remarks on angina pectoris. N Engl J Med 1962 Jan 4;266:3-7*