Postpartum Weight Loss—How Much?

Postpartum weight change: How much of the weight gained in pregnancy will be lost after delivery? Greene G, Smiciklas-Wright H, Scholl T, and Karp R. OBSTET GYNECOL 71:701, 1988.

In this analysis of data from the Collaborative Perinatal Study, 7,116 women who had two births within the 6 year study period were evaluated for weight changes between pregnancies as well as weight loss postpartum. Since obesity is considered "the major nutritional problem affecting women in western industrialized nations" this study sought to tie prenatal weight gain to increasing obesity.

Seventy-three percent of these women were heavier at the start of their second pregnancy, and 12% gained 15 lb or more between pregnancies. Multiple regression analysis of a multitude of factors which might have affected weight changes showed that the preponderance of the change in weight between pregnancies could be attributed to prenatal weight gain. In general, women who gained more than 20 lb during pregnancy retained 5.7 to 10.2 lb by the start of their second pregnancy. Of this, only 1 lb per year could be attributed to the natural tendency to gain weight over time.

These data were collected from 1959 to 1965 when more severe restriction of prenatal weight gain was advised, however, the authors feel the results should still be applicable to a similar population today. They are not applicable, however, to women who breastfeed.

The authors note that it is often recommended that women gain more than 20 lb in pregnancy, especially those at risk for low birth weight or premature infants, and that obstetricians must be sensitive to concerns about excessive weight retention.

Teaching Perinatal Ethics

Perinatal law and ethics rounds. Fleischman A, Rhoden N. OBSTET GYNECOL 71:790, 1988.

These authors perceived a need for more attention to the ethical and legal aspects of clinical decision-making in perinatal medicine. They developed a case-oriented teaching program which included all professionals involved in the care of pregnant women and their newborns. The rounds were concrete and patient-centered, not abstract discussions of ethical principles.

The goals of the program were: 1) to develop skills in moral diagnosis, 2) to understand relevant laws, 3) to instill an awareness of the complexity of ethical decision-making, 4) to appreciate the legal and ethical relationships between the pregnant woman, her fetus and the professionals, and 5) to encourage frank and open discussion of these issues. Cases were presented in detail, in lay language, including all relevant medical information, possible and probable outcomes and prognosis, and a statement of the ethical or legal question posed by the specific case.

After discussion each participant is asked to briefly state and defend his or her opinion, and then the ethicist or lawyer elaborates the relevant principles or laws and sums up the main points.

The authors feel that this use of a philosopher-ethicist and a lawyer in medical education appears to be an effective and useful approach to teaching clinical decision-making in obstetric and pediatric medicine.

New Protocols for Management of Herpes

Management of genital herpes infection in pregnancy. Infectious Disease Society for Obstetrics and Gynecology. OBSTET GYNECOL 71:779, 1988.

These new protocols endorsed by the above-named group include the abandonment of routine weekly prenatal cultures for women with a history of herpes infection but without current lesions. They recommend only a single culture taken on the day of delivery in order to detect potentially exposed infants.

In women with lesions at or near term, they recommend cultures taken at 3 to 5 day intervals to assure the absence of virus at the time of delivery. They continue to recommend cesarean section as a means of "reducing the risk of neonatal herpes infection," especially within 4 to 6 hours of membrane rupture.

0091-2182/89/$03.50