Editorial

As this is the first issue of 2011, I would like to take this opportunity to update our readers on a few improvements in the journal, highlight some of the obstetric articles we published in the past year, and address a mea culpa to the authors who submitted manuscripts to the journal in the past 6 months.

JOURNAL IMPROVEMENTS

In this issue, you will notice some major changes to the composition of our board members. The editorial team of the American Journal of Perinatology (AJP) is proud to announce that Drs. Catalin Buhimschi and Martin Keszler have agreed to take on the newly created position of Associate Editor. They are both accomplished clinicians, educators, and researchers in maternal-fetal medicine and neonatology, respectively. More importantly, they both contributed significantly to the mission and quality of the journal during their tenure as editorial board members. As Associate Editors, they will be active in managing the flow of the submitted manuscripts and selecting reviewers. They will also solicit editorials and topic reviews for the journal. We ask you to assist them in their task by agreeing to their request as much as possible. We also encourage you to email them with ideas and suggestions. In addition, we have expanded the editorial board for obstetrics and neonatology to add expertise and geographic diversity. The editorial board members are leaders in research, academic and scientific societies, and institutions. They are also active clinically and represent a worldwide view of the specialty. They will provide their expertise through the review process, and by advocating for the journal and our specialties. Lastly, AJP will no longer publish case reports. These submissions will be routed to AJP Reports, a companion journal to AJP that is devoted to case reports. We believe that case reports are mostly accessed when clinicians are faced with patients who have unusual or rare conditions. For this reason, the case reports in AJP Reports will be open access and available for free to anyone.

HIGHLIGHTS OF OBSTETRIC STUDIES PUBLISHED IN 2010

One hundred and thirty-one articles were published in AJP in 2010. In addition to experts in the field, each of the original contributions was personally reviewed and evaluated by the Editors in Chief and deemed of high quality for the journal. It would take me several pages to summarize all of them, but I would like to highlight a few that I think will likely result in a change in management in the next few years.

Using a large registry of cesarean sections, investigators from the NICHD Maternal-Fetal Medicine Units Network compared outcome of women undergoing cesarean section following a prior classical versus a prior lower transverse cesarean. As would have been expected, women who had a prior classical cesarean were more likely to have uterine dehiscence in future pregnancies. More importantly, however, women with a prior classical cesarean had longer total operative time and hospital stay, as well as higher intensive care unit admission than women with prior lower uterine transverse incisions. While the immediate consequences at the time of classical cesarean may not be too dire, this study highlights the long-term consequences and underscores the need to endeavor to use a lower uterine segment approach as much as possible.

The same database was used by Ramirez et al to shed some light on a dilemma that often faces clinicians, namely what is the safest method to deliver a patient who had a prior cesarean section and who now has a fetal demise. Out of 209 patients in the dataset with prior cesarean delivery presenting with an intrauterine fetal demise, 75.6% (158/209) attempted a trial of labor, and the vaginal birth after cesarean (VBAC) success rate was 86.7%. Labor induction or augmentation occurred in 83.3% of attempted VBAC. Uterine rupture occurred in five women (2.4%) and in 3.4% of those being induced but none of these required hysterectomy. The findings of this study are reassuring and support attempts at vaginal delivery in women with prior cesarean delivery who present with fetal death in the current pregnancy.

Bollepalli and colleagues examined neonatal morbidity in infants of type 1 diabetic women according to whether fetal abdominal growth was symmetric with...
the rest of the biometry or not. They compared four groups of offspring (asymmetric large for gestational age [LGA], symmetric LGA, asymmetric non-LGA, symmetric non-LGA) exposed in utero to maternal type 1 diabetes. Neonatal morbidity (respiratory distress syndrome, polycythemia, hypoglycemia, hyperbilirubinemia, acidosis, and composite morbidity [any of the five]) was assessed. Asymmetric LGA infants had 3.5-, 2.2-, and 3.2-fold greater odds of hypoglycemia, hyperbilirubinemia, and composite morbidity, respectively, compared with symmetric non-LGA infants. This study indicates that evaluation of fetal abdominal circumference may potentially be used as a marker to identify the asymmetric LGA and thereby aid in the identification of newborns at greatest risk for perinatal complications.

Refuerzo et al\textsuperscript{4} used a dataset from 552 twin pregnancies enrolled in a multicenter, randomized trial performed within the NICHD Maternal–Fetal Medicine Network to compare neonatal outcomes following moderately preterm birth (MPTB), late preterm birth (LPTB), and term birth. MPTB was defined as delivery between 32\textsuperscript{w}7 and 33\textsuperscript{w}6 weeks and LPTB between 34\textsuperscript{w}0 and 36\textsuperscript{w}6 weeks. Primary outcome was a neonatal outcome composite consisting of one or more of the following: neonatal death, respiratory distress syndrome, early-onset culture-proven sepsis, stage 2 or 3 necrotizing enterocolitis, bronchopulmonary dysplasia, grade 3 or 4 intraventricular hemorrhage, periventricular leukomalacia, pneumonia, or severe retinopathy of prematurity. Compared with term neonates, the neonatal outcome composite was increased following MPTB (relative risk [RR] 58.5; 95% confidence interval [CI] 11.3 to 1693.0) and LPTB (RR 24.9; 95% CI 4.8 to 732.2). Twin pregnancies born moderately and late preterm encounter higher rates of neonatal morbidities compared with twins born at term.

In 2010, we also published a systematic review performed by a prolific Dutch group to estimate the risk of delivery before 34 weeks due to recurrent hypertensive disorder in women with prior history of pregnancy-associated hypertension.\textsuperscript{5} The search retrieved 36 relevant articles, of which 11 fulfilled the inclusion criteria. These 11 studies reported on 2377 patients (range 18 to 1754 patients per study), who had 2461 deliveries. Seven studies were included for further calculation. The pooled risk of a delivery before 34 weeks due to recurrence of hypertension, preeclampsia, or HELLP was 7.8% (95% confidence interval 6.7 to 9.0%). While the recurrence rate of pregnancy-related hypertension may be elevated, the risk of delivery before 34 weeks due to a recurrent hypertension remains low.

Using data from an NICHD Maternal Fetal Medicine Units Network randomized trial in laboring, low-risk, nulliparous women at 36 weeks’ gestation, Contag and colleagues\textsuperscript{6} compared neonatal outcome after forceps, vacuum, or cesarean performed in 990 women for failure of descent or nonassuring fetal status in the second stage of labor at station +1 or below (thirds scale). Birth outcomes and umbilical cord blood gas values were similar for those neonates with a forceps-assisted, vacuum-assisted, or cesarean delivery in the second stage of labor. The occurrence of significant fetal acidemia was not different among the three delivery methods regardless of the indication.

In the United States, management of abnormal placental invasion, referred to as placenta accreta, almost always involves cesarean hysterectomy. A report from Israel we published in the journal last year challenges this paradigm. Sivan et al\textsuperscript{7} presented a case series of 30 patients, as a relatively large cohort of women, with suspected placenta accreta who underwent prophylactic pelvic artery catheterization prior to cesarean section. Placenta accreta was clinically confirmed in 25 (83.3%) cases. Embolization was performed in 23 cases (76.6%) and hysterectomy in 2 (8%). Median estimated amount of blood loss was 2000 mL (500 to 9000 mL). There were no major catheterization-related complications. Three women had a subsequent pregnancy and uncomplicated delivery by cesarean section. This report shows that prophylactic pelvic artery catheterization and embolization in women with placenta accreta may prevent hysterectomy in women with placenta accrete, and should be considered in woman wishing to preserve fertility.

Several publications in 2010 revolved around obesity and weight gain in pregnancy. Obesity is an exploding epidemic, and excessive weight gain during pregnancy may be fueling it. We published a pilot study that showed that a lifestyle modification program in pregnancy can achieve 75% compliance and be effective in reducing gestational weight gain in obese women.\textsuperscript{8} This study opens the way for a clinical trial of sufficient size to determine the effect of gestational weight gain control on pregnancy outcomes. Zhong et al\textsuperscript{9} investigated the association between prepregnancy maternal body mass index (BMI) and preterm delivery (PTD) in 44,421 American women with singleton gestation presenting for care in Saint Louis, Missouri between 1990 and 2006. This large study with well-characterized pregnancies showed that prepregnancy obesity increases the risk of preterm premature rupture of the membranes (PPROM) and decreases risk of spontaneous PTD without PPROM. Excessive gestational weight gain was also found to be associated with preeclampsia and cesarean delivery in 20,823 obese women reported by Flick and colleagues.\textsuperscript{10} An effect of obesity on pregnancy outcomes was also found in triplets. Using data from 667 women with triplet pregnancies, Russell et al found that obese women with triplet gestations have about 4- and 3-fold elevated risks for stillbirth and preeclampsia as compared with their counterparts with normal weight.\textsuperscript{11}

These are just highlights of few of the studies published in AJP in 2010. I encourage you to review these as they may lead you to change practice.
MEA CULPA

I would like to address an unfortunate anomaly that has beset the journal in the past year; namely the delays in reviewing and turning around manuscripts. I take full responsibility for these deficiencies. I would like to offer all those affected a sincere apology and a promise that this will not be a problem in the future. Our target is that 80% of submissions will have a decision within 4 weeks from initial submission and 2 weeks for revised submission. Many of the changes in the structure of the editorial board were aimed at shortening the submission-to-decision interval. I am indebted to my co-Editor in Chief, Dr. Rose Higgins, to AJP's editorial assistant Joanne Vasami, and to Daniel Schiff from Thieme Medical Publishers for their assistance and counsel.

Finally, I also would like to thank all our readers, subscribers, reviewers, and authors for your support. I urge you to keep following our publications in the journal as there are many more outstanding issues to come. Dr. Higgins and I will endeavor to maintain the high quality of what is published in the journal, and keep it relevant to clinical practice, while at the same time bridging obstetrics and neonatology. I wish all of you a happy, healthy, and prosperous 2011.

George R. Saade, M.D.1

Editor in Chief

REFERENCES


