Letters to the Editor

Does preconception care improve perinatal outcome?

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I am writing in reference to the article 'Does preconception care work?' by Beckmann and coworkers[1]. I support the authors' aim of improving perinatal outcome and it seems intuitive that preconception care involving the reduction of maternal risk factors would achieve a healthier outcome for mother and baby. However, before funding preconception counselling, one needs to be sure that it works.

The primary outcome of the study, the likelihood of being 'healthy', was assessed by a range of 'interim' measures not perinatal outcome. Interim measures included: preconception weight gain, cessation or reduction of smoking, folate supplementation, vaccination and consultation with a specialist. These indicators were measures of recommendations made to women in the treatment group during the 45-min consultation with a midwife and obstetrician. So, the study measured whether women exposed to preconception care did what they were instructed in their preconception consultation compared to women who did not receive preconception care. It is therefore not surprising that women who received preconception care had better interim 'outcomes' than women who did not receive preconception care. In addition to this, two of the interim measures were change in weight and change in BMI, and these are not independent of each other.

Furthermore, although those women who did not receive preconception care were similar to those who did on a number of measures, they did have a poor pregnancy outcome, including a preterm birth rate of 30%. This is substantially higher than what is seen in Australia overall[2] and higher than what would be expected in a tertiary referral centre. This suggests that the between-group difference is more a result of a poor outcome in the comparison group than a good outcome in the intervention group. An important risk factor for preterm birth is prior preterm birth[3] and yet the prevalence of this risk factor in the two groups of women is not reported (although their history of miscarriage is similar).

Beckmann *et al.* acknowledge that women who pursue preconception care are likely to be health conscious. At the conclusion of the article, the authors suggested that a less biased method of substantiating these findings would be a randomised controlled trial. Although they acknowledge that a randomised trial would have ethical challenges, a method of unbiased and ethical data collection such as a birth registry (which already exists in every state in Australia) could be used to collect data on preconception care. Such registries already include data on a range of risk factors, including smoking and BMI as well as some information on previous obstetric outcome.

References

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Response: Does preconception care improve perinatal outcome?

We are grateful to Dr Dempster for her interest in our paper.[1] Given the limited uptake of preconception care and the paucity of data on the benefits of such an approach, we devised and implemented a program built upon foundations of health promotion. Strategies to promote positive lifestyle change are typically ineffective or short-lived. We were indeed surprised to observe that a coordinated approach to prepregnancy care might make a difference across several heath domains. Whilst the same number of women in each group reported planning their pregnancy, we observed that those exposed to this model of care were more likely to change their behaviour. The observed differences in preterm birth were also unexpected. Amongst multiparous women included in the analysis, the incidence of prior preterm birth did not differ between cases and controls (5/25 versus 7/74); hence, this does not appear to explain the observed difference.

The addition of data points to state birth registries would in theory serve to identify those who had been exposed to some aspect of preconception care. However, we hypothesise that there are significant differences between a discussion with a GP about a future pregnancy in a time-pressured 15-min consultation, and the multidisciplinary systematic approach to prepregnancy health provided in a dedicated preconception service.

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Reference

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Managing the breech presentation at term: the place of pelvimetry

Dear Editor,

I read with interest the Newcastle experience of managing breech presentation at term.[1] I was disappointed they stated that '*computerised tomography pelvimetry was performed as standard until 2004 when, with minimal evidence to support this utility, the practice was ceased*'. Borbolla Foster *et al.*[1] refer to the 2006 publication of Goffinet *et al.*[2] on the *Premoda Study*. This study relied heavily on pelvimetry with 82.5% of women who were planning to have a vaginal delivery having this assessment. I published a letter in *ANZJOG* ten years ago, citing four articles as good evidence to support pelvimetry.[3]

I believe that it would be a very worthwhile exercise for the Newcastle group to perform pelvimetry retrospectively on the women whose infants had serious neonatal morbidity and low 5-min Apgar scores and received care in NICU for more than four days, as per Table 2,[1] and report their findings.

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The value of imaging pelvimetry in the management of the breech presentation at term

Many thanks for the comment about pelvimetry and its value in the management of breech presentation at term following our recent publication.[1] There were several reasons for abandoning pelvimetry. Firstly, from 1999 to 2004 we found that there was poor correlation between pelvimetry and birth outcomes. Secondly, we felt that the most important precaution with breech vaginal birth was labour progress, no matter how adequate the pelvimetry. Thirdly, it was unusual to find a woman with a truly contracted pelvis. Sophisticated algorithms using fetal size and detailed MRI pelvimetry measurements have not been shown yet to improve maternal and neonatal outcomes.[2] Finally, evidence from a randomised trial using MRI pelvimetry as a selection criteria for breech vaginal birth found that it did not correlate with adverse outcomes.[3] However, this study did show that there was a lower frequency of emergency caesarean delivery when the result of the MRI pelvimetry was available to the clinician.

The good outcomes for breech vaginal birth in the PREMODA study were likely due to several factors rather than a single major benefit from pelvimetry.[4] The studies in support of pelvimetry, quoted by Dr McMaster Fay in this journal ten years ago, relied on older radiological technology and had limited numbers.[5] It would be difficult to perform pelvimetric measurements on all the women whose babies had suboptimal short-term outcomes.

Pelvimetry, as currently performed, adds little value to the effective management of breech presentation at term.

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