

Panniculectomy at Time of C-Section Is Feasible

BY KERRI WACHTER

FROM THE ANNUAL MEETING OF THE AMERICAN COLLEGE OF OBSTETRICIANS AND GYNECOLOGISTS

WASHINGTON – Modified panniculectomy at the time of cesarean section may be a useful adjunct for decreasing postoperative morbidity in morbidly obese patients, based on results of a small case series.

“We found that women who underwent panniculectomy at the time of cesarean section were less

likely to have significant wound complications than controls that did not undergo panniculectomy,” Dr. Pedro Miranda-Seijo said in a poster presentation at the meeting.

He and his coinvestigators conducted a chart review during 2004 that included 30 morbidly obese patients who underwent incidental panniculectomy during cesarean section and a control group of 29 morbidly obese women who underwent a cesarean section without a panniculectomy.

The definition of morbidly obese was a body mass index (BMI) of greater than 42 kg/m².

“The decision to perform a panniculectomy was made originally by me before starting surgery, at which time I would obtain informed consent,” Dr. Miranda-Seijo said in an interview.

“After I’d done the first 10 or 15 cases, the residents and other attending began trying to schedule elective cases on morbidly obese patients on days that I would

be available; often I would see these patients during their antepartum visit and discuss the procedure with them,” said Dr. Miranda-Seijo, who is an obstetrician at Denver Health and Hospitals.

“I am the only attending that does these procedures; [patients] understand that if they come in labor and I’m not available, they would not be getting a panniculectomy,” he said.

Also “when a morbidly obese patient who is in labor needs a cesarean section, if I’m available, I often get called to do it,” he commented.

“If the indication is urgent but not emergent – say failure to descend or secondary arrest of dilation – and I will be available in a few hours, the case is often held for me to do when I arrive,” he said.

Notably, the women in this series who underwent panniculectomy had significantly greater BMIs – a mean of 54 vs. 49 kg/m² for the control group.

Of the 30 women who underwent modified panniculectomy at the time of cesarean section, there was one operative site infection that required readmission.

In contrast, in the control group there were seven late wound complications and three readmissions.

The difference in late wound complications was significant.

There was a nonsignificant difference in operative time, with a mean of 66 minutes with a panniculectomy compared with 63 minutes for cesarean section alone.

Panniculectomy did not significantly increase blood loss.

“The extra time needed to infiltrate the skin, remove the pannus, and [close] the large incision is offset by the greater speed achieved in accessing the uterus, delivering the baby, and closing the uterus and fascia, due to better exposure and easier access,” he commented.

Several questions were raised by the study: Does the removal of so much adipose tissue have an effect on glucose tolerance, and could this procedure be

used by patients as a starting point to initiate healthier lifestyle changes?

Additional research will be needed to provide answers, Dr. Miranda-Seijo said.

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Modified panniculectomy at the time of cesarean section on morbidly obese patients did not significantly increase blood loss.



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VITALS

Major Finding: Of the 30 women who underwent modified panniculectomy at the time of cesarean section, there was one operative site infection that required readmission. In contrast, in the control group there were seven late wound complications and three readmissions. The difference in late wound complications was significant.

Data Source: A chart review during 2004 that included 30 morbidly obese patients who underwent incidental panniculectomy during cesarean section and a control group of 29 morbidly obese women who underwent a cesarean section without a panniculectomy.

Disclosures: Dr. Miranda-Seijo reported that he had no relevant financial disclosures.

High Carb Intake Raises Gallbladder Disease Risk

BY HEIDI SPLETE

FROM THE ANNUAL DIGESTIVE DISEASE WEEK

CHICAGO – The risk of gallbladder disease was more than twice as high in pregnant women in the top quartile of carbohydrate consumption, compared with those in the bottom quartile, based on data from a prospective study of 3,070 pregnant women.

Female sex is a risk factor for gallstones, and pregnancy is an especially high-risk time for gallstone development, Dr. Alexander Wong of the University of Washington, Seattle, said at a press conference.

“Gallbladder disease is the most common nonobstetrical cause of maternal rehospitaliza-

tion the first 60 days after delivery,” said Dr. Wong.

“Carbohydrate intake has been linked to increased risk of cholecystectomy in women.

“However, the effect of carbohydrate intake on gallbladder disease during pregnancy is unclear,” he commented.

To determine the effect of diet during pregnancy on gallstone formation, Dr. Wong and his colleagues performed ultrasounds on pregnant women during each trimester and at 4-6 weeks post partum.

The average age of the women was 25 years, and each had at least two interpretable ultrasounds. Women who had gallstones at the first ultrasound and those with a history of gallstones were excluded.

Overall, the cumulative incidence of new gallstones or biliary sludge indicative of gallbladder disease was 10%. In addition, women in the highest quartile of starch consumption were 80% more likely than those in the lowest quartile to show signs of gallbladder disease.

In addition, those in the highest quartile of fructose consumption had double the risk, compared with the lowest quartile, of showing signs of gallbladder disease. Dietary factors were assessed using standard food composition data.

Women who formed sludge or stones were more likely to have a higher caffeine and alcohol intake, be of Hispanic origin, and gain less weight during pregnancy.

By contrast, the highest quartile of galactose intake was independently associated with a decreased risk of gallbladder disease, compared with the lowest quartile, noted coauthor Dr. Cynthia Ko, also of the university, who presented the study results at the press conference. The results held after control for variables including age, prepregnancy weight, ethnicity, smoking, diabetes, total calorie intake, alcohol intake, and weight gain during pregnancy.

“We believe that high carbohydrate intake during pregnancy may stimulate even more insulin release, therefore increasing the negative effects of hyperinsulinemia on bile composition,” Dr. Wong said.

“The fructose finding is fairly

novel,” added Dr. Ko.

“We hypothesize that fructose is metabolized differently than many other carbohydrates,” she said.

High fructose intake can cause insulin resistance, which can predispose individuals to gallstone formation, she noted.

“The galactose finding is quite novel, and we don’t have a good scientific explanation for why we found that,” Dr. Ko added. “This is a very preliminary finding that needs further confirmation and explanation.”

The results suggest that cutting down on refined, processed carbohydrates during pregnancy might reduce a woman’s risk of gallstones, Dr. Ko commented.

Dr. Ko said she had no relevant financial disclosures.