'Video Doctor' Counsels on Weight Gain

Computer program gathers info on diet and exercise in pregnancy, and provides motivational counseling.

BY SHERRY BOSCHERT

SAN FRANCISCO — During prenatal visits at the University of California, San Francisco, pregnant women meet not only with clinicians but with a new "Video Doctor" designed to help them stay fit and avoid excessive weight gain during pregnancy.

The women use a laptop and headphones in the clinic to view video clips of an actress who plays a physician and asks them about their diet and physical activities and then provides motivational counseling in an interactive format.

"This really is a nice adjunct to the counseling that we do in the clinic," Dr. Naomi E. Stotland said at a conference on antepartum and intrapartum management sponsored by the University of California, San Francisco.

The Video Doctor program prints a "Provider Alert" sheet that the woman can bring to her clinician "so the clinician can see what's going on and reinforce the counseling," said Dr. Stotland of the university.

She said she hopes the Video Doctor experiment will provide an effective, low-cost way of implementing basic strategies to limit excessive weight gain in pregnancy.

Recent studies suggest that working with a dietitian plus intensified monitoring and counseling by an ob.gyn. may reduce excessive weight gain in pregnancy in some populations, but these interventions are expensive and time consuming, she noted.

One randomized, controlled trial found that stepped-care behavioral interventions reduced excessive weight gain, compared with routine care, but only in women who had a normal body mass index before they became pregnant, she said.

Another study compared women who received provider counseling, plus a mailed patient-education newsletter, with historical controls and found that the intervention reduced the rate of excessive weight gain during pregnancy only in low-income women.

'This really is a nice adjunct to the counseling that we do in the clinic.'

DR. STOTLAND

Most recently, investigators randomized 100 pregnant women to intensive dietary and lifestyle counseling or routine care with no extra counseling.

The intervention was similar to recommendations by the American College of Obstetricians and Gynecologists for routine weight gain monitoring and counseling.

Patients in the intervention group gained significantly less weight in pregnancy than did controls (29 vs. 36 pounds) but did not meet the primary outcome of a significant improvement in the percentage of women whose gestational weight gain fell within limits recommended by the Institute of Medicine (Am. J. Obstet. Gynecol. 2009;113:305-12).

"We have a long way to go," Dr. Stotland said, "and these are kind of expensive things to implement. It's much, much more intensive counseling" than usual.

The Video Doctor may help with this, but a preliminary study showed only partial promise.

When used as a one-time intervention around the 20th week of pregnancy in a randomized, controlled trial, the Video Doctor was not associated with a difference in weight gain, but the women in the Video Doctor group did report better diets and physical activity behaviors and increased discussions about these topics at follow-up visits, Dr. Stotland said.

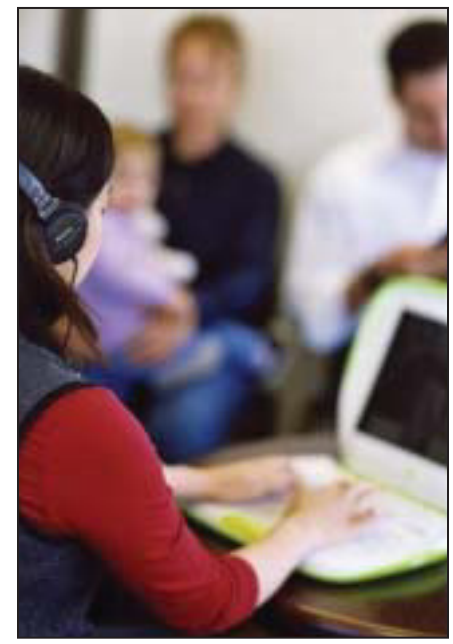
A new study will use a revised version of the Video Doctor that starts earlier in pregnancy and engages pregnant women in a serial fashion throughout pregnancy. The study also will incorporate other strategies such as self-monitoring of weight.

"We're hoping that as a package, this will reduce excessive weight gain in pregnancy, but we need to do more research," she said.

A large proportion of U.S. women gain excessive weight during pregnancy.

In a recent study of nearly 53,000 women in the United States who gave birth to term singletons in 2004-2005, 42% of those who were normal weight at baseline and 64% of those who were overweight at baseline gained more pounds during pregnancy than were recommended in the 1990 Institute of Medicine guidelines.

Among women who were obese at baseline, 46% gained more than 25 pounds above the Institue of Medicine-recommended amount (Am. J. Obstet. Gynecol. 2009;200:271.e1-7).



COURTESY KRISTIN GERBERT

A woman in a prenatal clinic connects with the Video Doctor for counseling on weight gain during pregnancy.

The Institute of Medicine in May 2009 revised its recommendations for weight gain in pregnancy to add an upper limit to recommendations for pregnant women who are obese at baseline.

In a comparison of the Institute of Medicine guidelines with 2002-2003 data from the Pregnancy Risk Assessment Monitoring System, overweight women gained a median of 30 pounds during pregnancy, compared with 20 pounds recommended by the IOM, and obese women gained 25 pounds, compared with the recommended median of 15.5 pounds, the Institute of Medicine found.

Dr. Stotland reported that she has no conflicts of interest related to these topics. ■

Rule Out Ectopic Before Starting Methotrexate, Physician Says

BY SHERRY BOSCHERT

SAN FRANCISCO — Empiric treatment with methotrexate for presumed ectopic pregnancy is a thing of the past, or should be, Dr. Amy "Meg" Autry said.

"You need to do a D&C before you treat with methotrexate" unless a definitive ectopic pregnancy is seen on ultrasound, she said at a conference on antepartum and intrapartum management sponsored by the University of California, San Francisco.

'I would imagine for some of you ... this is practice changing, and I think you should change.'

DR. AUTRY

The D&C will help rule out ectopic pregnancy and avoid giving the chemotherapy drug to the 71% of women with indeterminate ultrasound results who actually have an intrauterine pregnancy, said Dr. Autry of the university.

Multiple studies support the need for doing a D&C before beginning methotrexate treatment, she noted. Besides the data that found chorionic villi in 71% of 245 women who underwent a D&C after indeterminate ultrasounds (Acad. Emerg. Med. 1999;6:1024-9), the results of a separate study of 112 women showed that a presumed diagnosis of ectopic pregnancy (without D&C results) was inaccurate in 38% of cases (Am. J. Obstet. Gynecol. 2002;100:505-10). Another study found that empiric treatment with methotrexate did not reduce complications or save money (Fertil. Steril. 2005;83:376-82). An endometrial Pipelle biopsy was not a sufficient substitute for a suction D&C to diagnose ectopic pregnancy in a separate, blinded prospective study of 32 patients (Am. J. Obstet. Gynecol. 2003;188:906-9).

The accumulated evidence is "compelling," Dr. Autry said. "I would imagine for some of you in this room, this is practice changing, and I think you should change."

In a separate practice-changing development, there is now "pretty good evidence to show that it's cost effective and tubal protective" to give methotrexate prophylactically to women scheduled for salpingostomies for ectopic pregnancy, Dr. Autry said.

When choosing surgery for ectopic pregnancy, she said she may take out the fallopian tube with the ectopic pregnancy but leave the other tube if it looks normal.

Salpingostomy is associated with persistent trophoblastic disease in 5%-20% of cases, however, without prophylactic methotrexate. Compared with no prophylaxis, giving methotrexate at the time of salpingostomy reduced the risk of tubal rupture (0.4% vs. 3.7%) or future procedures (1.9% vs. 4.7%) and lowered overall cost ($67.55 less on average), one study found (Fertil. Steril. 2001;76:1191-5). Patients with ectopic pregnancies who are most at risk for persistent trophoblastic tissue after salpingostomy are those with very early gestations, ectopic pregnancies less than 2 cm in size, or very high starting HCG levels, Dr. Autry said.

Dr. Autry said she has no conflicts of interest related to these topics. ■

Gestational Diabetes Guides

The Agency for Healthcare Research and Quality is offering guides to help women with gestational diabetes and their doctors make informed decisions about treatment. The consumer guide is "Gestational Diabetes: A Guide for Pregnant Women," and the clinical guide is "Gestational Diabetes: Medications, Delivery, and Development of Type 2 Diabetes." For more information, call AHRQ at 800-358-9295. ■