REFERENCES


Recurrent partial mole

To the Editors:

Since the article on recurrent partial hydatidiform mole was published (Honoré LH. Recurrent partial hydatidiform mole: report of a case. Am J Obstet Gynecol 1987;156:922), we have seen two additional cases that we would like to present briefly.

In February and November 1986, patient No. 1, a 26-year-old woman, gravida 2, para 1, abortions 1, had two consecutive spontaneous abortions that were diagnosed pathologically as partial moles. The first abortion (46,XX karyotype) consisted of a ruptured sac with a grossly normal macerated embryo (crown-rump length 18 mm, developmental age 41 days, menstrual age, 12 weeks). The second abortion in November exhibited the ultrasonic and pathologic features of an empty sac despite a 46,XY karyotype. Diploid partial moles have been described.

Patient No. 2, a 39-year-old woman, gravida 5, para 3, abortions 2, developed two consecutive partial moles in October 1986 and March 1987. The first mole (47,XX,+15), expelled at 10 weeks' gestation, consisted of a ruptured sac with many nucleated red blood cells in the chorion and villi that suggested the presence of a formed embryo that was normal or focally abnormal. The second mole (47,XX,+9), passed at 9 weeks' gestation, was an empty sac diagnosed ultrasonically and pathologically, with a severely growth-disorganized, 1 by 1 by 1 mm embryo. Partial moles can be trisomic.

From this small series, one can tentatively draw three conclusions. (1) Recurrent partial moles are more frequent than is generally realized, i.e., about 2% (3/129 studied cases); (2) there is worsening of the embryopathy without worsening of the histologic diagnosis; (3) repeat moles exhibit similar cytogenic features, whether diploid or aneuploid.

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Parity and the contraceptive sponge

To the Editors:

The recent article by McIntyre and Higgins (McIntyre SL, Higgins JE. Parity and use-effectiveness with the contraceptive sponge. Am J Obstet Gynecol 1986;155:796-801) is an attempt to represent a complex subject in simple terms and fails to consider all of the many issues relating to pregnancy rates among users of the Today contraceptive sponge. The inference of these authors that contraceptive sponges should be available in multiple sizes is without foundation.

Although complex statistical models were used by McIntyre and Higgins, their analyses failed to consider some of the fundamental issues that must be addressed when pregnancy rates are evaluated among parous and nulliparous contraceptors. Paramount among these issues is that of future childbearing. In the studies of the contraceptive sponge conducted by Family Health International, the future childbearing intentions of women were determined by a single question that required a simple yes/no answer. Without considering future childbearing intentions, the parity-specific pregnancy rates associated with the use of the sponge cannot be evaluated adequately. One approach is to separate pregnancies into those attributed to failure of the method (method-related pregnancies) and those attributed to the failure of women to use the sponge consistently and correctly as directed (user-related pregnancies). The assessment of whether there is a significant difference in the pregnancy rates of parous and nulliparous spongers should be based on the analyses of the method-related pregnancy rates that are less affected by future pregnancy intentions than are user-related or total pregnancy rates.

All pregnancies reported during the phase III clinical trial of the sponge were reevaluated and reclassified as either method or user failures by means of menstrual data, coital log data (when available), the physician's and woman's determination of whether the pregnancy was a method or user failure, and any other pertinent information supplied by the woman or clinic. Of the 171 reported pregnancies, 13 could not be classified as either method or user failures. These 13 pregnancies were arbitrarily and conservatively classified as method failures. Pregnancies were excluded if they occurred either before the woman entered or after she left the study. (For reasons that are not apparent, McIntyre and Higgins included pregnancies if they occurred 7 days before entering or 7 days after leaving the study.) The resulting 1-year, method-related life-table pregnancy rates (per 100 women) on the basis of the worldwide studies of the Today sponge were 7.8 ± 1.0 for 1088 nulliparous women and 8.7 ± 1.2 for 954 multiparous women (Effectiveness of the Today vaginal contraceptive sponge. Unpublished data of VLI Corporation,
submitted to the Food and Drug Administration, April 28, 1986, Vol 3). These rates do not differ significantly \( (p > 0.10) \). In the Yugoslavian study of 403 sponge users, the 1-year method-related pregnancy rates were similar \( (p > 0.10) \) for nulliparous and parous women.\(^2\) The multiclinic United States data analyzed by McIntyre and Higgins included only 184 multiparous women, whereas the Yugoslavian study included 285 multiparous women. If the higher pregnancy rate among United States sponge users was due to anatomic factors related to parity, the same should hold true for Yugoslavian women. I am unaware of anatomic differences among women relating to their country of origin!

In a comparative, multiclinic study of cervical cap and diaphragm users in the United States,\(^3\) the 1-year pregnancy rates (by life table) were about twice as high for parous women compared with nulliparous women for both methods of contraception that were available in multiple sizes. Quite clearly, these data show that among barrier contraceptive users factors other than the size of the contraceptive must have an important effect on the pregnancy rates experienced by parous women. These data support the contention that the higher pregnancy rate for parous sponge users is not related to its size.

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Reply
To the Editors:

Attribution of the cause of contraceptive failures is difficult, especially for vaginal contraceptives. In our study we found that parous women were twice as likely as nulliparous women to become pregnant if they were using the Today contraceptive sponge. We did not find this pregnancy risk differential in the comparison group of women using the diaphragm with spermicide. The difference in parity-specific pregnancy risk persisted for sponge users when we considered only those pregnancies that were judged by the study investigators to be method related. Because the date of conception is difficult to pinpoint, we included estimated dates of conception that were placed up to 7 days before admission and 7 days after a study participant's leaving the study.

In an attempt to determine why the parous sponge users in our study were at greater risk of pregnancy, we were able to eliminate undiagnosed primary sterility among nulliparous sponge users as a probable cause. We also determined that the level of difference by parity in contraceptive compliance and intention to avoid pregnancy did not appear to offer a likely explanation. However, we did find that parous sponge users were less likely than nulliparous sponge users to have an induced abortion after contraceptive failure.

We also pointed out that the developer of a contraceptive sponge without spermicide had determined that it was important to have a larger-sized sponge for parous women. If the effectiveness of the Today sponge is due primarily to the action of the spermicide it carries, then increasing the size of the sponge beyond what is required to deliver spermicide may be of little benefit. The size of the sponge may be critical if a significant part of the effectiveness of the sponge is its ability to block sperm from entering the cervix. In our study, however, we did not conclude that the Today contraceptive sponge should be available in multiple sizes.

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Influences of perinatal asphyxia on respiratory distress syndrome

To the Editors:
The proceedings of the workshop addressing the results of the Collaborative Study on Antenatal Steroid Therapy and the Prevention of the Respiratory Distress Syndrome (1976-1983) were presented recently in a Clinical Opinion article (Avery ME, Aylward G, Creasy R, Little AB, Stripp B. Update on prenatal steroid for prevention of respiratory distress. AM J Obstet Gynecol 1986;155:2-5). An extensive review of the results was provided with the same important omission noted in all previous reports. No consideration was given to the possible influences of perinatal asphyxia on these findings despite numerous observations that fetal acidosis and low Apgar scores are associated with an increased incidence of respiratory distress syndrome.\(^1-5\) Differences in umbilical arterial pH and in Apgar scores would indicate confounding labor complications that might alter the reported results. This omission was pointed out in a previous Letter to the Editors in this JOURNAL in 1981.\(^2\) Responding to that inquiry, the Collaborative Group\(^6\) affirmed that fetal asphyxia and neonatal Apgar scores were important outcome variables and proclaimed "one paper addressing these is currently in preparation."

To our knowledge a careful assessment of these important variables has not yet been published. In a National Institutes of Health publication citing the results of the Collaborative Group in Antenatal Steroid Therapy, it was reported that "the analyses of umbilical artery and venous cord blood gases did not show an effect of steroid therapy (data not shown) . . . RDS infants had blood gases and pH which were not significantly different from those in the non-RDS group."

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