Ultrasonographic screening for trisomy 21

To the Editors: In the article by Lockwood et al. (Lockwood CJ, Lynch L, Berkowitz RL. Ultrasonographic screening for the Down syndrome fetus. AM J OBSTET GYNECOL 1991;165:349-52) the authors estimate the positive predictive value for Down syndrome of both the biparietal diameter/femur length ratio and measured femur length/expected femur length ratio for a given biparietal diameter. To calculate this predictive value they used a prevalance of Down syndrome (1/710) that reflects the incidence of Down syndrome at 16 weeks' gestation for the general population. An alternative estimate of the prevalence in a target population might include all pregnancies in women <35 years of age and 50% of woman >34 years who do not have amniocentesis. This formula would lower the prevalence (assuming there are 4.2 million live births per year[1], that 8.6% of live births occur to women >34 years of age, that 39% of Down syndrome births occur in women >34 years,[2] and that Down syndrome occurs in 1/1000 live births) to 1/884 at 16 weeks and reduce the positive predictive value to below the levels cited by approximately 20% to 30%.

Additionally, there appears to be an error in the estimate of predictive value for study 9 in Table I. The correct positive predictive value should be 1/108 rather than 1/644.

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REFERENCES

1. Wegman M. Annual survey of vital statistics: 1990. Pediatrics 1991;88:1081-92.
2. Goodwin BA, Huether CA. Revised estimates and projections of Down syndrome births in the United States, and the effects of prenatal diagnosis utilization, 1970-2002. Prenat Diagn 1987;7:342-6.

Reply

To the Editors: We thank Bernstein for his analysis of the positive predictive value of the various biparietal diameter/femur length formulas for detecting fetal Down syndrome. He is correct in his analysis of this alternate approach to the estimation of positive predictive values. In addition, he rightly points out a typographic error in study 9. The positive predictive value of this study is indeed 1/108 rather than 1/644.

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What is the prognosis for congenital cytomegalovirus infection?

To the Editors: We read with interest the article by Lynch et al. (Lynch L, Daffos F, Emanuel D, et al. Prenatal diagnosis of fetal cytomegalovirus infection. AM J OBSTET GYNECOL 1991;165:714-8). This article demonstrates the usefulness of a comprehensive evaluation of fetuses with possible congenital cytmegalovirus infection. Although the numbers are small (6 of 7), it appears that women who have a documented primary infection during pregnancy can be reassured if their fetus has normal blood studies, normal ultrasonographic findings, and a negative amniotic fluid culture.

Although we agree that the prognosis is likely to be poor for congenitally infected infants who are detected solely on the basis of abnormal ultrasonographic findings, this is not certain. There has been at least one case in which ascites diagnosed at 27 weeks' gestation completely resolved before birth at 36 weeks' gestation.[1] This infant had minimal findings at birth.

The natural history of congenital cytomegalovirus infection is still not known in detail. We agree that more long-term follow-up of fetuses and neonates known to be infected in utero is needed.

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REFERENCE

1. Binder ND, Buckmaster JW, Benda GI. Outcome for a fetus with ascites and cytomegalovirus infection. Pediatrics 1988;82:100-3.

Response declined

Omental graft made simple

To the Editors: Since my article (Petty WM, Lowy RO, Oyama AA. Total abdominal hysterectomy after radiation therapy for cervical cancer: use of omental graft for fistula prevention. AM J OBSTET GYNECOL 1986;154:1222-6) was published, it has been found that it is not usually necessary to make a pedicle graft of the omentum to attach it to the vagina. Normally the omentum is long enough to reach the vaginal apex without being on tension. If the omentum will reach the vaginal apex without being on tension, it can be gently sutured to the vaginal apex with two interrupted absorbable sutures after the vagina is closed. I have only had to make a pedicle graft once in approximately 12 additional cases. The other 11 times the omentum has reached the vagina without being on tension. Therefore a simplified method of preventing fistulas after either full radiation therapy or a partial radiation therapy with hysterectomy is to simply suture the distal omentum to the vaginal apex. It is quick, easy, takes only 2 minutes, and has completely prevented fistulas in my patients.

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Ovarian cancer screening

To the Editors: The issue of screening for ovarian cancer is a timely one: it is of particular concern not only to