

comes at a compromise — loss of transparency. Moreover, parameters in multilevel models carry a subject-specific interpretation (as opposed to population-averaged interpretation in other simpler, nonnested model forms). Importantly, these models are prone to break down easily in the setting of smaller studies with multiple levels of nested data.

The third assertion is that studies with small sample sizes from single institutions will result in false-positive findings if they use our proposed comparability score. We disagree. The effect of our proposed comparability scoring system should be exactly the opposite. As a matter of fact, in our article, we provide 2 examples from previously published studies<sup>2,3</sup> from single institutions in which the presupposed positive statistical associations disappeared once the analysis was adjusted for our comparability score, thus decreasing false-positive results. ■

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## Fetal lung maturity testing

**TO THE EDITORS:** I agree with the recent article by Towers et al<sup>1</sup> about the use of fetal lung maturity (FLM) testing in select patients and express similar concern about the American Congress of Obstetricians and Gynecologists (ACOG) Committee Opinion that states, “amniocentesis for the determination of fetal lung maturity in the well-dated pregnancy should generally not be used.”<sup>1,2</sup> My maternal-fetal medicine practice is located in a vast and rural state with long and harsh winters. Many rural hospitals have discontinued their labor and delivery units, leaving patients with long drives to reach a hospital with obstetric services. Other rural hospitals offer limited obstetric services and frequently refer higher-risk patients to more advanced-level hospitals.

As an example, a patient was recently referred to our service so she might have the opportunity for a trial of labor after cesarean. This patient resided some 200 miles from our hospital. She had a successful vaginal delivery with her first pregnancy, then a cesarean with her second pregnancy for a fetus in breech position. With her third pregnancy, she had a strong desire for trial of labor after cesarean and was considered an excellent candidate. However, if the patient entered spontaneous labor while at home, she would have undergone a repeat cesarean because her local rural hospital does not allow for patients who desire vaginal birth after cesarean (VBAC). Therefore, at 38 weeks’ gestation, we performed amniocentesis for FLM. The results were mature, so we proceeded with induction of labor following ACOG

guidelines. The patient had a successful VBAC and both mother and infant returned home safely.

Without amniocentesis to confirm FLM, we would have had to wait until 39 weeks’ gestation to proceed with elective delivery. However, this would have increased the risk of spontaneous labor while at home and reduced the likelihood of a successful VBAC for this patient. In our practice, this is a relatively common dilemma. Some patients live quite an extended distance from a hospital that can provide the level of care they need. In certain clinical scenarios, it can be difficult to determine optimal time of delivery, especially for patients who live quite a distance from the hospital.

FLM testing is not something to be routinely performed, but there are circumstances where it can be beneficial. Given the recent increased emphasis on avoiding elective delivery <39 weeks, use of FLM testing in select patients can be a valuable tool for reducing overall risks to the patient and fetus and improve the quality and safety of the care we provide. ■

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## Estimation of date of confinement: should paper gestational age wheels be abandoned?

**TO THE EDITORS:** We read the interesting and important study by Chambliss and Clark<sup>1</sup> where the estimated date of confinement (EDC) obtained from paper gestational age wheels was compared with that calculated using electronic techniques (APPs) downloadable to mobile/smart phones. The majority of mechanical wheels studied did not generate the correct EDC although all the APPs did. Also, the EDC obtained from wheels of similar sources differed. The authors in their conclusion suggested that paper gestational age wheels should be abandoned. This recommendation may not be of public health interest particularly in low and middle income countries (LMIC) and has the potential of leading to more medical errors.

Paper gestational age wheels are cheap and readily available for use in LMIC. Every healthcare worker in LMIC may not be able to afford a smart phone. The provision of smart phones (with downloadable APPs to calculate EDC) by Health Care Authorities in LMIC may have huge cost implications and redirect finances from essential health services. Abandonment of paper gestational age wheels by facilities that cannot afford appropriate mobile phones will therefore force healthcare workers to calculate EDC off by heart. This is prone to error in a busy unit if the health personnel are not used to such tasks.

The use of smart phones' APPs has other limitations. Because smart phones are expensive, they are prone to being stolen despite their capabilities of being tracked and/or blocked if lost. Although attending to pregnant patients, the battery charge of a phone may be low and not able to power the device for the APPs to be used. The situation will even be more frustrating if there is no immediate means of charging the battery. Furthermore, some health workers may require

extra training to learn how to use smart phones and their APPs.

It is possible that wear and tear following prolonged usage of paper mechanical wheels evaluated in the study led to incorrect EDC they generated. Likewise, faulty mobile phones/APPs will also give wrong EDC.

Rather than the abandonment of paper gestational age wheels, stringent quality check should be introduced to ensure that reliable products are manufactured. Even in settings where APPs are available, calculation of EDC by any 2 of paper wheel, APPs or off by heart methods will assist in cross-checking the result of each against the other to prevent error. This may be the most appropriate approach. ■

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## Transgender patients care

**TO THE EDITORS:** We commend the *American Journal of Obstetrics and Gynecology* editors and Cecile A. Unger for the outstanding comprehensive Expert Review on the care of transgender patients for gynecologists.<sup>1</sup> This thorough and concise update highlights the need for all gynecologists to be competent in providing medically appropriate and culturally sensitive care to gender non-conforming and transgender patients. The roles of

gynecologists are crucial for this vulnerable population who face significant barriers and obstacles in our health care systems.

We want to provide clarification regarding 2011 WPATH guidelines on the process by which a transman would receive a hysterectomy. On page 21, Dr Unger states: "Masculinizing procedures such as mastectomy require documented gender dysphoria and a mental health