TABLE
Barriers to implementation of traditional group prenatal care models and Moms2B's approach

GPNC barriers	Moms2B CGM response to barriers
Accepts only women with low-risk pregnancies	All low-income pregnant women are welcome, including those with high-risk pregnancies
Requires adequate space for group sessions in clinics	Community based and can be easily implemented in churches and other public meeting spaces
Children of pregnant women are not allowed at the prenatal group sessions	Provides developmentally stimulating childcare for children of all ages
Appointments must be scheduled in groups based on women's gestational age	Sessions are held at the same time every week in the same setting. Women of all gestational ages attend together. Once delivered, women are encouraged to continue to attend with their children until their newborn's first birthday.
It is difficult to recruit and retain women at the same gestational age to maintain a cohesive group experience	Referrals come from multiple sources: prenatal clinics, WIC clinics, and community outreach. Women are excited to attend and often develop close relationships with other mothers in the community.

CGM, community group model; *GPNC*, group prenatal care; *Moms2B*, CGM model; *WIC*, Women, Infants, and Children.

Gabbe. The case for Moms2B. Am J Obstet Gynecol 2018.

other sites and details regarding the program are available from the authors. ■

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REPLY

We are excited to learn of other programs working to improve the quality of prenatal care for women in the United States. We appreciate the authors' comments. ■

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3D transvaginal sonography in obstetrics and gynecology

TO THE EDITORS: We certainly agree with the authors, Lee and Yoon,[1] in that 3-dimensional transvaginal ultrasonography (3D TVS) clearly offers additional clinical value as a diagnostic imaging tool, well beyond 2D TVS. The identification of a ureteral calculus within the ureter provides a good example of this value; such use should be encouraged and

broadened. One can even say that, with the confirmatory diagnosis from the use of 3D TVS, the other imaging modalities (eg, computed tomography) may not have even been necessary to use in this case.

In fact, the authors of 1 of the references that was cited in this article[2] stated that "visualization of the ureters could be incorporated into standard gynecological pelvic examination without significant increase in the examination time." Those authors stated that this could be done "particularly in women with a history of pelvic pain." Moreover, we have many similar examples of the clinical value of 3D TVS for other routine gynecologic diagnoses. ■

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REPLY

We appreciate the insightful comments expressed by Drs Levine and Fernandez regarding our recent report on the ureter stone diagnosed with 3-dimensional (3D) transvaginal ultrasonography. We absolutely agree with the authors' opinion that the 3D sonography provided additional useful information to the 2-dimensional sonography. As Drs Levine and Fernandez commented, the imaging studies that were performed to confirm the diagnosis of distal ureteral stone in our case might not be needed in other cases, considering the additional cost and radiation exposure.

Although not necessary in every case, 3D sonography is highly useful in the differential diagnosis of congenital uterine anomalies because the coronal image of 3D sonography provides both the outline of endometrial cavity and external fundal contour of the uterus.

Some authors reported the accuracy of 3D sonography to be comparable with that of magnetic resonance imaging.[1] 3D sonography also enables doctors to confirm the relationship of the leiomyoma to the endometrium. The main body of leiomyoma can be located without performing a sonohysterogram, which can sometimes be painful for the patient. We also think the rendered 3D sonography is also helpful in the removal of intrauterine lesions, such as endometrial polyps or injuries, that are caused by impacted intrauterine devices with various shapes.[2] The more precise localization of intrauterine lesions enables targeted curettage without requiring an office hysteroscopy. However, we look forward to performing a more extensive study that will evaluate the usefulness of 3D sonography in the diagnosis of gynecologic diseases. ■

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Comment on: Predicting the difficulty of operative vaginal delivery by ultrasound measurements of the fetal head station

TO THE EDITORS: I read with interest the study by Kasbaoui et al,[1] who investigated the clinical usefulness of measuring the perineum-to-skull ultrasound distance to predict the difficulty of operative vaginal delivery. However, I cannot agree with the conclusion reached. To perform operative vaginal delivery, I believe that the position of the