

Letters to the Editor

Group Prenatal Care to Reduce Preterm Labor and Improve Outcomes

Original Article: Preterm Labor: Prevention and Management

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To the Editor: We would like to thank Drs. Rundell and Panchal for their article. Although there is existing literature regarding group pregnancy care as a model to reduce preterm delivery, at the time of the article's publication, the model had not yet been formally endorsed by the American College of Obstetricians and Gynecologists (ACOG) or the American Academy of Family Physicians (AAFP).

We are pleased to recommend the group prenatal care model as an added intervention to Drs. Rundell and Panchal's recommendations for prevention of preterm delivery. In March 2018, ACOG in collaboration with the AAFP released a committee opinion in support of group prenatal care.¹ This opinion notes that in addition to offering important social and educational support for all patients, group prenatal care may offer additional benefits to the highest risk patients, including reductions in preterm delivery and low infant birth weight among black women.

Facilitated group prenatal programs, typically modeled after CenteringPregnancy, are designed to improve patient knowledge and social support, as well as health assessments (additional information available at <https://www.centering-healthcare.org>). Outcomes in group prenatal care models are comparable with those of traditional care. In addition, studies demonstrate high levels of patient satisfaction and improved perinatal outcomes for some populations.² ACOG's support aligns well with research findings that show CenteringPregnancy lowers preterm birth rates by 33% to 47%,¹ equalizes the racial disparity in preterm birth rates between black and white women,³ and increases breastfeeding rates.⁴

Send letters to afplet@aafp.org, or 11400 Tomahawk Creek Pkwy., Leawood, KS 66211-2680. Include your complete address, e-mail address, and telephone number. Letters should be fewer than 400 words and limited to six references, one table or figure, and three authors.

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This series is coordinated by Kenny Lin, MD, MPH, Deputy Editor.

Group prenatal care offers an opportunity to transform the delivery of care to patients in a way that supports individuals and communities, addresses equity in health care delivery, and improves important outcomes such as preterm delivery and low birth weight in vulnerable populations.

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Author disclosure: Drs. Darby-Stewart and Strickland are board members for the Centering Healthcare Institute.

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In Reply: We appreciate Drs. Darby-Stewart and Strickland bringing the recent ACOG bulletin to our attention. The bulletin clearly recognizes that group prenatal care, regardless of the specific model, is a viable alternative to individual prenatal care and may be more beneficial in certain patient populations. Some of the benefits include improved patient knowledge and readiness for labor and delivery, as well as satisfaction with care. There is also evidence of increased rates of breastfeeding.¹ Although there is mixed evidence for the effect of group prenatal care on preterm birth outcomes overall, analyzed by race and income, there is clear evidence for improvement in preterm birth outcomes for low-income black women.²⁻⁴

In addition to supporting group prenatal care, we would like to add that the ACOG bulletin now includes a recommendation for a single course of betamethasone for women between 34 0/7 and 36 6/7 weeks' gestation who have a risk of delivery within seven days if they did not previously receive a course of steroids antenatally.⁵

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Registered Dietitian Nutritionists Should Be Included in Patient Health Care Teams

Original Article: Diets for Health: Goals and Guidelines

Issue Date: June 1, 2018

See additional reader comments at: <https://www.aafp.org/afp/2018/0601/p721.html>

To the Editor: I was surprised and disappointed to see that, except in passing, the critical role of registered dietitian nutritionists (RDNs) as an integral part of a patient's health care team—and as a valuable partner for any family physician—was not explored in the article, and that the Academy of Nutrition and Dietetics was not listed as a patient resource in Table 6. It is well within the RDN's scope of practice to provide education and counseling for all of the barriers to a healthy diet noted in Table 5.

Medical nutrition therapy provided by a qualified professional such as an RDN is linked to improved clinical outcomes and reduced costs related to physician time, medication use, and hospital admissions for persons with obesity, diabetes mellitus, disorders of lipid metabolism, and other chronic diseases.¹

Patients correctly view physicians as a trusted source of information and treatment; physicians should determine the nutrition and obesity prevention and treatment messages they have the time and skill to provide to their patients. However, there is an important difference between advising patients on the basics and the in-depth counseling provided by an RDN who has the knowledge and skills needed to help individuals make changes that can affect outcomes. Referring patients to RDNs "could be one of the most important ways that health care professionals help patients learn about, implement and sustain behavior changes."²

The Academy of Nutrition and Dietetics maintains a national, searchable online referral service enabling consumers and clinicians to locate an RDN in their area (<https://www.eatright.org/find-an-expert>). It also offers a free

continuing medical education–accredited webinar on how RDNs add value to physicians' practices (<https://www.eatrightstore.org/product-type/webinars-and-presentations/primary-care-plus-how-a-registered-dietitian-nutritionist-adds-value-to-your-practice>).

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In Reply: Thank you for sharing your insight and this excellent resource. Educating physicians about the composition of a healthy diet is an important first step; however, the next and perhaps more important step is to help patients change behavior. Helping patients make lifestyle changes—and dietary change in particular—is a challenging task that does not fit well into a short office visit with competing demands. One of the best ways to do this is through a team-based care approach. Although not available in some practices, dietitians have a critical role. Many patients need much more than an overview of dietary recommendations. Dietitians are often the most highly qualified member of the team to help patients take the next step in making actual dietary change. A number of studies have shown the benefit of adding a dietitian team member.^{1,2}

Physicians have an opportunity to advocate for expanded coverage of dietitian services for their patients. They also can consider creative ways to involve dietitian expertise in the office setting. Dietitians can provide medical nutrition therapy, assist in coaching patients, join in shared medical appointments, provide cooking demonstrations, and in some cases teach cooking classes to patients. If the U.S. health care system is successful in transitioning to a value-based system, services such as these will likely be highly sought after because they have the potential to make a substantial impact on disease prevention and treatment.

Although this short article was about the specifics of diet and not about treatment, implementation of diet change is an important topic. Physicians will be unable to dramatically change the lifestyles of our populations alone. We will need to work with many professions, including dietitians, to achieve this monumental task.

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Point-of-Care Ultrasonography: An Effective Tool When Used Appropriately

Original Article: Point-of-Care Ultrasonography in Family Medicine [Editorials]

Issue Date: August 15, 2018

See additional reader comments at: <https://www.aafp.org/afp/2018/0815/p200.html>

To the Editor: The editorial by Drs. Bornemann and Barreto describes a broad range of possible uses of point-of-care ultrasonography (POCUS) in primary care. With appropriate training, there is a good evidence base for the use of POCUS in patients with possible skin abscess, suspected community-acquired pneumonia, and left ventricular dysfunction.

However, it is always important to remember the potential harms and unintended consequences of introducing a new diagnostic or screening test. For example, the authors include the use of POCUS to identify thyroid lesions, a practice that is likely to do far more harm than good. In countries where physicians routinely scan the thyroid using POCUS, there is an epidemic of overdiagnosis: detection of small lesions of undetermined significance that are too often treated as cancer, resulting in considerable morbidity.¹ For example, widespread use of POCUS in South Korea led to a more than 10-fold increase in the incidence of thyroid cancer, with no effect on mortality.¹ POCUS should be used only by clinicians with adequate training, and in clinical scenarios in which there is solid evidence that its use improves patient outcomes.

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Reference

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Editor's Note: Dr. Ebell is Deputy Editor for Evidence-Based Medicine for *AFP*. He was formerly a member of the U.S. Preventive Services Task Force and currently serves as

editor-in-chief of *Essential Evidence Plus*, a primary care medical reference.

In Reply: Dr. Ebell brings up an excellent point, with which I agree wholeheartedly. Although the physiologic risk of ultrasound waves on human tissue is very low, there are significant risks relating to the potential for overdiagnosis of pathology that would have otherwise remained subclinical. As smaller, less expensive “pocket” ultrasound machines are becoming increasingly available, the risk of increasing rates of overdiagnosis must be taken into consideration.

POCUS should be used only when the best available evidence suggests that the benefits will outweigh the risks. In the example that Dr. Ebell used, individuals were screened for thyroid cancer with ultrasonography leading to overdiagnosis and overtreatment. The key point here is that these individuals were *asymptomatic*. The evidence is strong that asymptomatic individuals should not be screened for thyroid cancer because the harms clearly outweigh the benefits.¹

However, POCUS still has the potential to be beneficial in the evaluation of thyroid nodules that are already clinically evident. In individuals who have a palpable thyroid nodule or a nodule that was found incidentally on imaging, ultrasonography can stratify the risk of malignancy and determine the need for evaluation via fine-needle aspiration.² Furthermore, if a nodule is found to be high risk, ultrasound guidance can improve the effectiveness of fine-needle aspiration over palpation-based techniques.³

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Corrections

Misspelled name. The Practice Guideline “Bleeding with Anticoagulants: ACC Releases Expert Consensus Decision Pathway to Guide Management” (July 1, 2018, p. 57) contained an error by referring to vitamin K agonists rather than vitamin K antagonists in three places within the last section titled “Using Reversal Agents” on page 58. The online version of the Practice Guideline has been corrected. ■