Letters to the Editor

Send letters to Kenneth W. Lin, MD, MPH, Associate Deputy Editor for *AFP* Online, e-mail: afplet@aafp.org, or 11400 Tomahawk Creek Pkwy., Leawood, KS 66211-2680.

Please 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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Screening for Gestational Diabetes Should Be a Shared Decision

TO THE EDITOR: A 32-year-old white woman 24 weeks into her uncomplicated first pregnancy had a fasting blood glucose level of 77 mg per dL (4.3 mmol per L) that increased to 142 mg per dL (7.9 mmol per L) one hour after a 50-g glucose loading test, which was interpreted as a positive screening result for gestational diabetes mellitus. She declined further testing and was told by her physician that she was putting herself and her baby at unnecessary risk. She wanted to know the evidence basis for this statement.

Two randomized controlled trials, both with approximately 500 pregnant women in each arm, compared intensive treatment for gestational diabetes with usual care.[1,2] Interventions included dietary counseling and insulin therapy for those with persistently high blood glucose levels. Women in the intervention groups gained less weight (difference of approximately 2 kg [4.4 lb]) and had less preeclampsia, fewer newborns with birth weights greater than 4 kg (8 lb, 13 oz), and a lower risk of shoulder dystocia compared with those in the control groups. Based on these trials, the U.S. Preventive Services Task Force recently recommended routine screening for gestational diabetes after 24 weeks' gestation.[3] However, the results of these trials may not be generalizable to this patient because one study included women with fasting blood glucose levels up to 140 mg per dL (7.8 mmol per L),[1] and the other recruited mostly nonwhite participants.[2]

A multinational study of more than 20,000 women found that the fasting glucose level is as accurate as one- or two-hour levels after a 75-g glucose load in predicting maternal and infant morbidity, and that the risks increase linearly with glucose levels.[4] Based on this study, the patient's fasting glucose level put her at a slightly increased risk of birth injuries (1.3% vs. 1.1%) and of preeclampsia (4.8% vs. 4.0%). Others have proposed a fasting blood glucose threshold of 85 mg per dL (4.7 mmol per L) to identify women who do not have gestational diabetes.[5]

In light of this information, the patient decided against further testing or treatment, and at 41 weeks' gestation delivered a healthy girl weighing 3.3 kg (7 lb, 4 oz). Her physician's approach was inconsistent with the evidence on the benefits of screening for gestational diabetes, and likely caused her unnecessary anxiety. We recommend a personalized approach to such screening, taking into consideration patient preferences and being careful not to exaggerate potential benefits or minimize potential harms.

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Corrections

Inconsistent recommendations regarding Tdap vaccination. Two articles in the October 15, 2013, issue contained incorrect and inconsistent recommendations regarding ▶

the administration of tetanus toxoid, reduced diphtheria toxoid, and acellular pertussis (Tdap) vaccination in pregnant women. The article "Recommendations for Preconception Counseling and Care" (p. 499) contained an error in the second column (Recommendations) of the second to last row (Tetanus, diphtheria, pertussis) of Table 2 (p. 501). The statement should have indicated that the optimal timing for Tdap vaccination during pregnancy is 27 to 36 weeks' gestation, rather than 27 to 30 weeks' gestation. The article "Pertussis: A Reemerging Infection" (p. 507) contained an error in the fourth paragraph under the "Vaccine Recommendations" header (p. 512). The second sentence in this paragraph should have indicated that the preferred timing of Tdap vaccination administration in pregnant women is at 27 to 36 weeks' gestation, rather than in the third or late second trimester. Therefore, the sentence should have read: "Women should receive a single dose of Tdap during each pregnancy, preferably at 27 to 36 weeks' gestation."

Additionally, in the article "Pertussis: A Reemerging Infection," the last recommendation in the SORT table (p. 508), the second sentence in the third paragraph under the "Vaccine Recommendations" header (p. 512), and the fifth row in Table 4 (p. 512) all contained incorrect information regarding Tdap vaccination in persons 65 years and older. The fifth row in Table 4 contained incorrect information regarding Tdap vaccination in persons 19 to 64 years of age. The last recommendation in the SORT should be omitted, and instead, the sixth recommendation should have read: "The Tdap vaccine should be administered to adolescents and adults, including those 65 years and older, in place of a single Td booster when such a booster is due." In Table 4, the recommendation for Tdap in persons 19 to 64 years and in persons 65 years and older should have read: "Single dose in place of a Td booster." The second sentence in the third paragraph under the "Vaccine Recommendations" header should have read: "In addition, adults 65 years and older should receive Tdap." The next sentence should be omitted. The online versions of these articles have been corrected.

Incorrect ceftriaxone dosages (missing "per kg"). The article "Otitis Media: Diagnosis and Treatment" (October 1, 2013, p. 435) contained incorrect dosages for ceftriaxone in the second and third columns of Table 3 (p. 437), failing to include "per kg"; these incorrect dosages also appeared in the original source article for the table. The correct dosage for both columns is as follows: 50 mg per kg IM or IV per day for one or three days, not to exceed 1 g per day. The online version of this article has been corrected. ■