Letters to the Editor

Strong Maternal Health Curriculum Needed in Family Medicine

To the Editor: I commend Dr. Ramírez on her well-written article describing an evidenced-based approach to prenatal care.[1] There is a need for a strong maternal health curriculum in family medicine residency programs. The 2023 revised Accreditation Council for Graduate Medical Education program requirements for family medicine continue to highlight the importance of family physicians providing care to pregnant patients, including low-risk prenatal care.[2] Although most graduates of family medicine residency programs will not continue to perform vaginal deliveries, more physicians who provide prenatal and postnatal care are needed in the United States.[3,4] According to the 2022 March of Dimes Maternity Care Deserts report, 36% of U.S. counties do not have an obstetric clinician of any type, affecting up to 6.9 million women.[4] The lack of access to prenatal care is also an issue of health equity. In 2020, 1 in 5 Black women (20.1%) did not receive adequate prenatal care compared with only 1 in 10 White women (9.9%).[4] As Dr. Ramírez states, a lack of prenatal care impacts maternal health.[1] From 2018 to 2021, the U.S. maternal death rate almost doubled to 33 maternal deaths per 100,000 live births.[5] For the first time in its publication's history, the March of Dimes report has highlighted that family physicians are "…an integral part of the maternity care workforce."[4] Family physicians go where others will not, providing care in 93.5% of U.S. counties.[4] One way to address maternity care deserts is to design residency curricula encouraging family medicineresidents to practice low-risk prenatal care after residency regardless of whether they perform deliveries. We must continue to develop collaborative systems of care where family physicians work as part of a larger health care team caring for pregnant patients. In Georgia, we have begun exploring the establishment of such systems, and we look forward to collaborating with others on this important work.

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Author disclosure: No relevant financial relationships.

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In Reply: I appreciate Dr. Lanham's comments and share the sentiment expressed in this letter. As noted by Dr. Lanham, family physicians are known to provide care to pregnant individuals with a higher burden on their health from a social determinants of health perspective.[1] With an estimated shortage of 9,000 prenatal care clinicians by 2030, the need for family physicians who provide prenatal care is glaring; however, 87% of family medicine residents opt not to provide this care after graduation, with those underrepresented in medicine being the least likely to provide this care.[1]

The United States has the highest number of pregnancy-related deaths in the developed world, and maternal health disparities continue to worsen. Black patients have a three times higher risk of pregnancy-related deaths compared with White patients.[2] Maternal health inequities in the United States are deeply rooted in racism, discrimination, and social determinants of health. Addressing maternal health equity must include the enhanced recruitment and retention of racially and ethnically diverse physicians, consistent with the 2003 Institute of Medicine report.[3] The U.S. population has become more diverse, but the same cannot be said for the physicians who care for them. Even 20 years after the publication of the Institute of Medicine report, only 1 in 5 family medicine residents was underrepresented in medicine (10% Hispanic/Latino, 9.3% Black or African American, 1.0% American Indian or Alaska Native, and 0.3% Native Hawaiian or other Pacific Islander).[4] Recruitment and retention of physicians underrepresented in medicine is hampered by the persistence of structural racism despite increased diversity, equity, and inclusion efforts.[5]

Achieving maternal health equity in the United States requires enhanced education and training, allowing for mitigation of the continued impact of structural racism, racism in medicine, and social determinants of health. Addressing factors that continue to perpetuate racial trauma for students, residents, and physicians underrepresented in medicine helps improve the recruitment and retention of a physician group known to be desired for the provision of prenatal care by minoritized communities.[6]

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Primary Aldosteronism Testing for Patients With Atrial Fibrillation

To the Editor: Thank you to Dr. Quencer and colleagues for an excellent article on primary aldosteronism.[1] I have two questions about testing for primary aldosteronism in patients with atrial fibrillation (AF):

- The authors recommend testing for primary aldosteronism in all patients with AF. Is this true even when blood pressure is normal? If so, can we expect the AF to resolve if the underlying aldosterone concerns are addressed and there are no other contributing causes?
- If a patient is normotensive, can we assume that they do not have primary aldosteronism, even with AF or other risk factors?

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In Reply: We thank Dr. Dudley for these questions on case detection testing for primary aldosteronism in patients with AF. Our article states that patients with AF and hypertension should undergo case detection with measurement of the aldosterone-renin ratio.

Although the most recent Endocrine Society guidelines do not include unexplained AF as an indication for case detection, they acknowledge that some institutions measure aldosterone-renin ratio for patients with new-onset AF.[1] A prospective study published in 2020 found that 42% of patients with nonvalvular AF had primary aldosteronism.[2] A meta-analysis found that AF was 3.5 times more common in patients with primary aldosteronism than in those with essential hypertension.[3]

The rate of primary aldosteronism in patients with unexplained AF is nearly 4 times higher than the rate in patients with well-established reasons to screen for primary aldosteronism (e.g., resistant hypertension).

Proposed causal mechanisms for development of AF in patients with primary aldosteronism include cardiac fibrosis, electrical remodeling, ventricular diastolic dysfunction, and hypokalemia.[4] With targeted medical or surgical treatment for primary aldosteronism, the prevalence of AF decreases to that seen in patients with essential hypertension.[5] Therefore, primary aldosteronism case detection should be considered in hypertensive patients with otherwise unexplained AF.

Normotensive primary aldosteronism exists but is rare.[6] It is typically discovered on workup for hypokalemia or an incidental adrenal nodule, and many of these patients develop hypertension. For practical purposes, patients with normal blood pressure do not need testing for primary aldosteronism, even with risk factors such as unexplained AF.

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