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(866) 423-7849

Hot Topics in Counseling Patients Who are Trying to Conceive

Narrator:
You're listening to Medical Breakthroughs from Penn Medicine, advancing medicine through precision diagnostics and novel therapies. The following program was recorded at Penn Medicine's live event, Hot Topics for the Primary Care Provider. Your host is Dr. Matt Birnholz. Dr. Birnholz welcomes Dr. Robert Debbs, Director of the Pennsylvania Hospital Maternal Fetal Medicine Network in New Jersey and Clinical Professor of Obstetrics and Gynecology. Now, here's your host, Dr. Matt Birnholz.

Dr. Birnholz:
Just a quick introduction for Dr. Debbs: He is a clinical associate professor of OB/GYN, Penn Medicine and director of the Pennsylvania Hospital Maternal Fetal Medicine network in New Jersey. Dr. Debbs also serves as the director of Maternal Fetal Medicine programs at Shore Hospital or Shore Memorial, Underwood Hospital, and most recently, Princeton Medical Center. So, Dr. Debbs, welcome to you.

Dr. Debbs:
Thanks for having me.

Dr. Birnholz:
I'm actually really looking forward to this interview. It's going to be a quick one, but you have encountered a number of questions that you get from the primary care sector in all sorts of therapeutic categories, diseased states and organ systems. We're just going to cover one each. So, Dr. Debbs, we start our whirlwind tour. Why don't we start with the overweight and obesity epidemic?

Dr. Debbs:
Sure.

Dr. Birnholz:
So, my question to you is from your vantage point as an OB/GYN, what is the importance of intervening prior to pregnancy in women who are overweight?

Dr. Debbs:
Probably one of the biggest paradigms that we have in maternal fetal medicine today is looking at the fetus as a patient in and of itself, and what we have learned and I think many of you in the audience have heard of what the Barker Hypothesis is, but we as maternal fetal medicine specialists know that babies get imprinted with diseased states while they are in the womb. The largest contributor to that is obesity. Women who are obese have children who are at double the risk of many different things – congenital malformations, adult onset heart disease, obesity as children, hypertension as teenagers, and even death in the first six years of life is increased twofold in women who have a BMI greater than 40 who go into pregnancy. So, we've done a lot in maternal fetal medicine to try and manage these patients while they're pregnant to reduce those risks, but it's simply not possible without pre-conceptual care, which is where you all come in. So, pre-conceptual identification of the reproductive age woman who wants to start a family is essential to get her on the right track to making those changes in her lifestyle prior to conception. That's the only way we're going to reduce the obesity rate in the United States, in that we have to stop the genetic imprinting of fetuses in the womb before these women get pregnant.

Dr. Birnholz:
This might be a little bit too nuanced, but one question that emerges from there is whether there is any differentiation that you place in pre-conceptual counseling between the woman planning on conceiving who is overweight versus the woman who is obese or even morbidly obese. Does you intervention planning change at all?

Dr. Debbs:
It does somewhat. Overweight women also have a relatively increased risk for a variety of different things, but when you get to class 2 obesity and your BMI is 35 or above, you start to double and triple the risk of things like congenital malformations and fetal death. In utero fetal death is three times higher in women who have a BMI over 35. The data on this is just voluminous. I mean, it's in every single study that we've looked at. It's astounding, and for many reasons, we're not quite sure why because even if they have a high BMI, they may not get diabetic; they may not get hypertensive during the pregnancy, but yet they still have these relative risks which are way higher than women with a BMI of 25 or less. So, yes, in your question, overweight women even who don't reach the level of significant obesity, still should be counseled pre-conceptually to their ideal body weight.

Dr. Birnholz:
I'm going to make a complete U-turn and switch to a completely different area.

Dr. Debbs:
Sure.

Dr. Birnholz:
. . .because I want to stay on this thread of pre-conception counseling but let's turn over to the cardiac issues. One area that you have received a question many, many times is whether women with repaired congenital heart disease can have safe pregnancies and deliveries.

Dr. Debbs:
For many years, women who had repaired congenital heart disease were told never to have children, and that's why my field became what it is today because we take care of these women all the time and they have wonderful outcomes, much like the diabetic years ago who was told never to have children or if they have kidney disease, you shouldn't have children. Ninety-nine percent of all congenital heart disease that has been repaired that does not have arrhythmias or thromboembolic disease do extremely well during pregnancy, and they can have normal births, and they do all the time. In fact, one of the biggest things we deal with is the fear of childbirth from the patient themselves – "Shouldn't I have a Cesarean section; "Should I go through the stresses of labor," and in fact, a major surgical procedure which is a C-section, which is probably the number one if not the number two most common surgical procedure in the United States, is more risky to a woman with repaired congenital heart disease than in a normal, well-controlled vaginal birth. The stresses of surgical intervention are way higher, so pre-conceptual counseling and a multidisciplinary approach for women who have repaired congenital heart disease is very, very important. In fact, we have an adult congenital heart disease center at Penn that deals with these situations every day, and we have now thousands of women who have had safe, healthy pregnancies with congenital heart disease.

Dr. Birnholz:
Why don't we continue with that theme that you mentioned, the fear of becoming pregnant that a lot of patients come into the clinic both primary care and obstetric care. One of the questions there for patients who have had a prior history of miscarriage is, "Can I have a safe pregnancy?" How do you respond to that?Dr. Debbs:
So, probably miscarriage is the most common thing we deal with in pregnancy because one in every three conceptions miscarries. So, the number is huge. There are four million pregnancies in the United States; a third of those are going to miscarry every year by things that we have very little control over, most of which are genetic related, so those are usually sporadic events that occur during myosis that you and I have no control over whatsoever. So, most women who have had one or two miscarriages can be assured that their statistical likelihood of a normal pregnancy is very, very high; however, the Association of Reproductive Medicine actually has changed the definition of recurrent pregnancy loss. It used to be that we wouldn't embark upon an extensive workup for pregnancy loss unless you had three or more repetitive, first trimester miscarriages or second trimester fetal deaths, because statistically they were likely to go on and have normal babies. In the United States, those numbers have somewhat changed in that there has been a bump in recurrence risk after two losses, and that's likely because of the aging population and the larger number of women entering pregnancy in their reproductive years with medical problems that may impact on miscarriage rates as well. So, after two losses now, we recommend a workup, but by far – and this is something that I deal with every single day that I practice – reassuring women who have had these events, which are very devastating. As a matter of fact, there is the book that I helped edit in Pennsylvania on the psychological problems in pregnancy loss, and there is a fair number of women when they miscarry at 10 weeks of pregnancy, their grieving process is very similar to those who have a loss later in pregnancy. It can be just as devastating. So, the psychological aspects are very important to deal with, but on a whole, we can reassure them that their odds are extremely high to have successful pregnancies.

Dr. Birnholz:
You were mentioning the psychological problems opened up another window for me that I have to now jump through, and that has to do with some of the psychiatric issues. One in particular that has come up a lot, of which you are interested, is for women with a history of depression and are antidepressants whether they can stop their antidepressants prior to conceiving and whether they should as well.

Dr. Debbs:
This is a very common topic. It's amazing how many women come to me on SSRIs or SSNRIs or other medications for mood disorders. The worst thing that we can do is after they conceive to stop all their medicines abruptly, and if I can give one pitch to all primary care providers is to not do that. Call me or call somebody to discuss with them, because 80% of these women will deteriorate dramatically and their disease state will worsen in a very short period of time when they abruptly stop all their medicines. It's a very common thing because everybody is afraid of the effects of different medications on fetal development, and there is a lot written on the subject. What most people don't talk about is that the magnitude of this risk for medicines like SSRIs is extremely small, so the relative risk may be higher. In some studies it's 1.8, 2.0, but when you look at the magnitude of the risk, we're talking about 1 in 1,000 pregnancies, and those risks are way smaller than the risk that all normal pregnant women take every day for a host of other issues like preeclampsia, fetal demise, or a maternal thromboembolic disease. So, the worst thing we can do is to abruptly stop these medications when they are pregnant. Before pregnancy, if you identify somebody who is planning to start a family, you may want to adjust their medication, and in some cases, you may find that a slow wean over time will do them a host of good because many of them started antidepressants because of a situational issue such as marital discourse or some issue in their family and they just tended to continue that medication for years and years on end, and there is a large group of these women who can safely wean off their medicines prior to pregnancy, but the caveat to that is that the outcome of these pregnancies is very good. There are still things that we don't know, but we do know that most of these medications do not cause congenital malformations despite what you may read on billboards riding down Route 70 by lawyers. The magnitude of the risk of congenital malformations is no different than the general population. In other words, the 3% risk of malformations in babies is the same on the majority of antidepressants that women are on and mood stabilizers as well. The issue is, is when you look at body systems separately, there is a slight bump in the relative risk of cardiac defects, but the magnitude of that risk is approximately 1 in a 1,000; 8 in 1,000 women will have a baby with congenital heart disease if they take nothing; 9 in 1,000 women will have congenital heart disease if they take a bunch of these medicines. The question is, is when you explain the magnitude of the risk to most patients, they are like, "Ah, I'd rather stay on my medication than take the chance of ending up in the hospital again for suicidal ideations."

Dr. Birnholz:
Is that a difficult idea/concept to be able to communicate to clinicians who have become very accustomed to thinking about relative risks rather than the magnitude? Is that something that you have to work through? Is that actually gaining traction now?

Dr. Debbs:
Yeah, absolutely; I mean, I think that we all have a duty to sort of put these in terms that our patients can understand, so when we talk about the magnitude of risk, it's extremely small and it's probably less than some of the risks that most people take every day, particularly when they're pregnant. For instance, eating too much tuna and getting mercury overload and having a baby with a lower IQ is probably higher risk than it is taking an antidepressant in many cases.

Dr. Birnholz:
So, I'm going to change gears again, moving to the endocrine side. One question involves hypothyroidism and whether or not it affects pregnancy outcomes.

Dr. Debbs:
That's a big topic, and we've been struggling with that for years in that does subclinical or even symptomatic hypothyroidism impact on the IQ of a baby? So, this is all based on a *New England Journal* article that came out over 15 years ago that suggested that if a woman has a TSH of greater than 10, their children had a much lower IQ than women who did not, and as is common in medicine, the data gets sort of bastardized over time and it became if your TSH is over 4, over 3, or over 5, and so now we have probably 20% of our population being treated for subclinical disease. The answer to your question is the landmark study that was just completed actually by the Maternal Fetal Medicine's network, which if you're not familiar with that, it's 13 institutions in the United States that do well done, large scale, randomized trials. Penn is one of the centers in the country. We finished that trial, the data came out, and subclinical hypothyroidism has absolutely no effect on long-term neuro-developmental outcomes. Now, there's a caveat to that. If women have risk factors such as other autoimmune diseases, infertility, obesity, or they are symptomatic, it does appear that in the first trimester a TSH level greater than 2.5, which all of us would say, "Ah, it's normal, right?" but a TSH level of 2.5 has a substantial relative risk of miscarriage in the first trimester. Only in the subgroup of women who have other symptoms or autoimmune disease, and women who have no other risk factors and have no symptoms, there is no increased risk for any pregnancy outcome that we worry about.

Dr. Birnholz:
And when you mention symptoms, you're saying these aren't subtle symptoms that one clinician might question. These are grossly apparent symptoms.

Dr. Debbs:
Absolutely, grossly apparent symptoms, yeah.

Dr. Birnholz:
Well, Dr. Debbs, obviously we could be here for quite some time. There are a lot of topics to cover, but we, in the interest of time, have to conclude. I want to thank you again for joining us.

Dr. Debbs:
Thank you.

[clapping]

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