

## A Message From the President of IIDSOG-USA

The International Infectious Diseases Society for Obstetrics and Gynecology-USA (IIDSOG-USA) held its Third Annual Meeting in New Orleans, May 9 and 10, 1998. During the meeting, there was a heated discussion about antepartum screening and treatment of infection to lower the incidence of preterm labor and delivery.

On May 14, 1998, based upon the discussion at the meeting, I drafted the following letter that was sent to the membership asking their response to this position statement.

### POSITION STATEMENT—PREVENTION OF PRETERM BIRTH

Prevention of preterm birth is an important goal of obstetrical care. The reason is obvious. Biologic immaturity at birth disproportionately contributes to infant morbidity and mortality as well as to the high costs of neonatal intensive nursery care.

Our assessment of published research, performed around the world, shows an association between genitourinary microbial abnormalities and prematurity. These conditions can exist either in asymptomatic women or in women with symptoms so mild they will not be brought to the attention of the health care provider. To ensure detection of women with genitourinary microbial abnormalities, a strategy of universal screening will have to be employed. This is not a foreign concept for obstetricians. For example, most American obstetricians practice universal screening of carbohydrate metabolism as a part of standard prenatal care. The weight of evidence more strongly supports infection screening than this endocrinologic endeavor.

We recognize and acknowledge that the associations between these microbial abnormalities and prematurity need further study. We support controlled intervention trials without a placebo arm to determine the best therapeutic strategies for these women. However, should all women at risk for prematurity be denied potentially helpful therapeutic intervention while we wait for the results of these trials? We do not think so.

We support antepartum screening for the following abnormal microbial conditions in pregnancy. These include bacterial vaginosis, asymptomatic bacteriuria, as well as lower genital tract colonizations with *Chlamydia trachomatis*, *Trichomonas vaginalis*, or *Neisseria gonorrhoea*. There are easy-to-use sensitive screening techniques available to determine these abnormalities and those patients who test positive should be offered safe and effective treatment.

The benefit of such a policy of intervention will require continuing assessment of both basic microbiologic and immunologic research as well as and clinical outcome studies. We believe such research will provide obstetricians and their patients new opportunities to further reduce the risks of infants being born too soon. The time for action is now.

To date, the majority of the responses have been favorable, with just under one quarter of the favorable responders suggesting changes in the text that improved

the quality of the English. Anyone familiar with my syntax can understand the magnitude of these responses. As you might expect with such a strong position statement, nearly one quarter of the membership did not favor the society taking this stand. All were concerned about either the lack of or paucity of data on the treatment of asymptomatic women and felt that further prospective studies are needed with a placebo arm. I have great respect for the scientific focus of the dissenters, but I don't agree with their stand. To withhold treatment for a patient with bacterial vaginosis requires a belief that this syndrome causes no problems for the pregnant woman. How can we deny one study after another that shows a relationship with BV and postpartum pelvic infection? Knowing this, how can anyone deny treatment when there are simple means to detect BV within minutes of every vaginal examination during pregnancy? I agree with the purists that a controlled prospective double blind study would be a satisfying exercise, but what about the use of historical data as the control database? I know of no one advocating a placebo arm for prophylactic antibiotic studies in cesarean section or colon surgery at the present time.

This should be grist for the mill of future discussion. What do the readers think?

The fourth annual meeting of the IIDSOG-USA will be held in Philadelphia, Pennsylvania on May 15 and 16, 1999, the weekend before the annual meeting of the American College of Obstetricians-Gynecologists. The society is pleased to announce that two distinguished speakers have accepted our invitation to join the meeting. Dr. Gordon Douglas, the former Chairman of Internal Medicine at Cornell University School of Medicine and now vice president of Merck Vaccines at Merck, Sharpe, and Dohme, will speak on "Immunization practices for the obstetrician-gynecologist, currently and in the future." In addition, Robert Good, PhD, MD, DSc, FACP, Distinguished Research Professor and Head of Allergy and Immunology, the University of South Florida Medical School, will speak on "Lessons concerning infectious diseases from study of patients with primary immunodeficiency diseases." I expect this to be an exciting and stimulating meeting for every attendee.

Sincerely,

*William J. Ledger, MD*  
*President, IIDSOG-USA*



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