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**IS PERIODONTITIS ASSOCIATED WITH PRETERM LABOR, PRETERM LOW BIRTH WEIGHT, AND PREECLAMPSIA?** *Vallejo, M.C.<sup>1</sup> Daftary, A.<sup>2</sup> Riegel, A.R.<sup>1</sup> Pbelps, A.L.<sup>1</sup> Kaul, B.<sup>1</sup> Mandell, G.L.<sup>1</sup> Ramnanatban, S.<sup>1</sup>* 1. Anesthesiology, University of Pittsburgh, Pittsburgh, PA; 2. Obstetrics, University of Pittsburgh, Pittsburgh, PA Introduction: Preterm labor, preterm low birth weight, and preeclampsia is reported to be 3 to 8 times more common in women with periodontal disease. 1 The purpose of this study is to determine if periodontitis is associated with preterm labor, preterm low birth weight, and preeclampsia. Methods: After local IRB approval, 85 preterm ( $\leq 37$  weeks gestation, n = 15) and term ( $\geq 38$  weeks gestation, n = 70) parturients in labor received a periodontal examination using the Periodontal Screening and Recording (PSR) system. PSR is a screening classification system endorsed by the American Dental Association. PSR scores range from code 0-4: (0 - healthy gingiva, 1- bleeding after probing, 2 - supra/subgingival calculus, 3 - probe depth > 3.5mm indicating mild periodontitis, 4 - probe depth > 5.5 mm indicating moderate to severe periodontitis). Results are expressed as mean  $\pm$  SD and analyzed using t-test or Chi-square. P < 0.05 is considered significant. Results: Results are expressed in the table. No differences were noted with respect to PSR scores, vaginal delivery rate, or in Apgar scores < 7 at 1 minute. The prevalence of periodontitis (PSR = 3 + 4) was higher in the preterm group (46.7% vs. 40.0%). As expected, both gestational age and birth weight were lower in the pterm group. Preeclampsia was significantly higher in the preterm group. More neonates in the preterm group had Apgar scores < 9 at 5 minutes. Conclusion: There appears to be an association between periodontitis, preterm labor, preterm low birth weight and preeclampsia. More research is needed to establish this relationship and to determine its mechanism. *JAMA 2000;283:2922.*

	Preterm	Term	P
Gestation (wks)	36.0 $\pm$ 1.0	39.5 $\pm$ 1.0	0.00
Preeclampsia (%)	26.7	2.9	0.01
PSR = 0 (%)	26.7	27.1	0.78
PSR = 3 + 4 (%)	46.7	40.0	0.85
Vag Del (%)	86.7	92.9	0.78
Apgar < 7 <sup>1</sup> ; (%)	13.3	8.6	0.93
Apgar < 9 <sup>5</sup> ; (%)	20.0	1.4	0.02
Birth wt (gms)	2778 $\pm$ 629	3566 $\pm$ 349	0.00

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**ASA PHYSICAL STATUS CLASSIFICATION - A PREGNANT PAUSE** *Barbeito, A. Schultz, J.; Muir, H.; Dwane, P.; Olufolabi, A.; Breen, T.; Habib, A.; Millar, S.; Drysdale, S.; Spahn, T.* Division of Women's Anesthesia, Duke University Medical Center, Durham, NC In 1941, the American Society of Anesthesiologists developed a six-category classification for patients requiring anesthesia and surgery. The ASA physical status classification was then modified into five categories by Dripps et al in 1961 and remains in use today with some changes. The advantages of the ASA classification are twofold: it provides anesthesiologists with a quick summary of the physical status of a patient and it allows us to compare outcomes. The inconsistency of ratings using this classification in surgical patients has already been shown. The objective of this study was to investigate whether this disparity of opinions also exists when referring to parturients. To explore the differences of opinion, and of practice, we asked a sample of anesthesiologists to rate specific hypothetical cases in regards to ASA classification. We presented three non-obstetrical cases and three obstetrical cases. Case 1: A 34 y/o male with GERD presenting for elective laparoscopic hernia repair. Case 2: A healthy 24 y/o female who will undergo left breast biopsy. Case 3: A healthy 19 y/o male with acute appendicitis presenting for emergent appendectomy. Case 4: A healthy 24 y/o G1P0 in active labor, requesting a labor epidural. Case 5: A 22 y/o G1P0 in active labor, developing early signs of pre-eclampsia. Case 6: A healthy 25 y/o in active labor presenting for urgent cesarean section for breech presentation. We found inconsistency in the ratings using the ASA physical status classification for surgical patients. This discrepancy appears even greater in parturients. While pregnancy is considered a "normal" physiological condition by some, others realize the increased risk due to the parturient's anatomic and physiologic changes. At least two studies have shown discrepancy in rating the ASA physical status classification in non pregnant patients. We found adding a simple modifier, the fact that a patient is pregnant, trends towards more inconsistency to this already imperfect system. Ways of improving this useful classification should be sought in order to allow physicians to communicate more effectively and to better compare outcomes. 1. Saklad M: Grading of patients for surgical procedures. *Anesthesiology* 2:281, 1941 2. Dripps RD, Lamont A, Eckenboff JE: The role of anesthesia in surgical mortality. *JAMA* 178:261, 1961 3. Owens WD, Felts JA, Spitznagel EL: ASA physical status classifications: A study of consistency of ratings. *Anesthesiology* 49:239, 1978

n=49	Case 1	Case 2	Case 3	Case 4	Case 5	Case 6
ASA I	11 (22%)	49 (100%)	34 (69%)	19 (39%)	0	17 (35%)
ASA II	38 (78%)	0	13 (27%)	30 (61%)	25 (51%)	29 (59%)
ASA III	0	0	2 (4%)	0	24 (49%)	2 (4%)
ASA IV	0	0	0	0	0	1 (2%)