Overview of module

• Elements of results with examples
  • First part describing study population
  • Second part answer your study questions
• Consistent across sections
  • with research questions
  • with methods
• Tips
“First Part”

Who is in study population.

- Table 1
- Text
Longitudinal study of quantitative changes in pelvic organ support among parous women

Victoria L. Handa, MD, MHS; Joan L. Blomquist, MD; Jennifer Roem, MS; Alvaro Muñoz, PhD

**TABLE 1**
Characteristics of the study population at the first study visit (i.e., study entry)

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<thead>
<tr>
<th>Variable</th>
<th>Cesarean only (n = 617)</th>
<th>At least 1 vaginal birth (n = 607)</th>
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<tbody>
<tr>
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Genital hiatus at study entry, cm

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Follow-up visits, n

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Values represent mean ± SD or percentage (n).

BACKGROUND: Pelvic organ prolapse is more common in multiparous women and also more common in those with assisted births. However, the exact timing and extent of the effect on the course of the genital hiatus opening is unknown.

OBJECTIVE: The objective of the study was to investigate the natural, quantitative changes in pelvic organ support after focusing on the impact of vaginal vs cesarean delivery.

STUDY DESIGN: This was a prospective longitudinal cohort study of parous women recruited 5–10 years from their first delivery and followed up annually. Using data from annual pelvic floor quantitative examinations, we examined changes in the position of each POPQ point (Ba, Bp, BpC, and the posterior wall support). In univariate and multivariate models, we compared pelvic organ support between women delivered at least 1 child vaginally vs those delivered exclusively cesarean. Other covariates considered included race, age, parity, and the size of the genital hiatus. For models of support, we included the 5-year mean value of each POPQ point (Ba, Bp, BpC) and the mean change per 5-year interval (n = 7055 woman-visits).

RESULTS: In the first decade after childbirth, pelvic organ prolapse is strongly associated with vaginal (vs cesarean) birth. Specifically, the odds of non-original prolapse to or beyond the hymen are 5 times higher among women with a history of vaginal births compared with women who have delivered by cesarean.

CONCLUSION: The association between vaginal birth and pelvic organ prolapse underscores the need for better understanding of how childbirth affects the course and progression of pelvic organ prolapse across a woman’s life span. Prior studies have suggested that prolapse may progress in some women but regress in others. The role of childbirth in the development and progression of prolapse is not well understood. A better understanding of the impact of childbirth on pelvic floor function would provide important insights into the prevention and treatment of pelvic organ prolapse.
# Longitudinal study of quantitative changes in pelvic organ support among parous women

Victoria L. Handa, MD, MHS; Joan L. Blomquist, MD; Jennifer Roem, MS; Alvaro Muñoz, PhD

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Airway changes following labor and delivery in preeclamptic parturients: a prospective case control study

P. Ahuja, a D. Jain, a N. Bhardwaj, a K. Jain, a S. Gainder, b M. Kang c

Results

Of 56 women assessed for eligibility, six were removed due to a protocol violation. Two patients from each group did not co-operate when attempting the Mallampati assessment, while airway sonography could not be performed for technical reasons in two parturients in the preeclamptic group. Data from 50 parturients were analyzed (see Fig. 2).
“Second Part”

• Answering study question with text, tables and figures

• Suggestions for writing results: focus on answering research question rather than statistical tests.
3.2 Low-lying IUDs and dysmenorrhea

Women with a low-lying IUD were more likely to report a “big problem” with dysmenorrhea in the past 12 months than women with a normally-positioned IUD (OR 3.2 95% CI 1.07-9.54) (Table 3). Although proportionately more women with a low-lying IUD reported dysmenorrhea that interfered with activities of daily living, the association was not statistically significant (Table 3). We found that women with a low-lying IUD were not more likely than those with normally-positioned IUDs to report choosing the IUD to alleviate menstrual pain symptoms (7.1% versus 8.6%, P=0.79, based on chi-square test), suggesting that the increased dysmenorrhea in the group with low-lying IUDs was not due to problems with dysmenorrhea prior to IUD insertion.
Women with a low-lying IUD were more likely to report a “big problem” with dysmenorrhea in the past 12 months than women with a normally-positioned IUD (OR 3.2, 95% CI 1.07-9.54) (Table 3).

“The odds ratio for IUD and dysmenorrhea was 3.2

“The association for IUD and dysmenorrhea was significant”

When XX increases, XX also increases.
Null Finding

Associations between missed opportunities and age, Hispanic ethnicity, Spanish language, or parity were not statistically significant.
Does the addition of active body warming to in-line intravenous fluid warming prevent maternal hypothermia during elective caesarean section? A randomised controlled trial

R. Chebbout, a R.S. Newton, b M. Walters, b I.J. Wrench, a, b M. Woolnough b

a The Medical School, University of Sheffield, Sheffield, UK
b Sheffield Teaching Hospitals NHS Foundation Trust, Jessop Wing, Sheffield, UK

ABSTRACT

Introduction: Inadvertent perioperative hypothermia occurs frequently during elective caesarean section but perioperative active body warming is not widely used. There is a paucity of evidence of its use in the obstetric population, and no applicable guidelines. We set out to identify a superior active warming method for preventing inadvertent perioperative hypothermia.

Methods: Following ethical approval, 132 women presenting for uncomplicated elective caesarean section under spinal anaesthesia were recruited. All participants received in-line intravenous fluid warming and were randomised to one of three parallel groups: no active body warming; forced air warming; and conduction mattress warming. The primary outcome was the difference in mean core temperature, measured on admission to the recovery room, between study groups. Core temperature and thermal comfort were measured perioperatively at 15-min intervals. Estimated blood loss, haemoglobin change, length of hospital stay and neonatal core temperature were also recorded.

Results: One-hundred-and-thirty-one women completed the study. There was no significant difference in mean core temperature on admission to the recovery room (36.6°C vs. 36.6°C vs. 36.6°C, \( \eta^2 = 0.005, P = 0.74 \)). Maternal hypothermia was prevented in all groups with only 0.3% hypothermic at any of the temperature measurements (3/1016). There was no difference in mean neonatal core temperature (36.3°C vs. 36.3°C vs. 36.3°C, \( \eta^2 = 0.003, P = 0.82 \)); however, 59.4% (76/128) of all neonates were hypothermic.

Conclusion: In-line intravenous fluid warming is sufficient to prevent maternal hypothermia and maintain core temperature. The addition of active body warming conferred no added benefit.
Tables and Figures

- Clear message
- Complement text
Fig 2. Multiple line graph of mean core temperature at each measurement point by study group (standard care: --e--, forced air warming: —, and conduction mattress warming: - -j- -). Error bars are ±2 SD from mean. *Significant difference between study groups.
Maternal $T_c$ was maintained throughout the study for all study groups (Fig. 2). There was no statistically significant difference in maternal $T_c$ on admission to the recovery room ($36.6 \pm 0.2^\circ C$ vs. $36.6 \pm 0.2^\circ C$ vs. $36.6 \pm 0.2^\circ C$, $g^z=0.005$, $P=0.74$), or at any other measurements, except 15-min after entry into the recovery room.
Consistency check

- Make sure research question is answered by your results
- Make sure the results reflect what is described in the methods
Summary

- Describe sample in table and text without repeating
- Focus on answering research question rather than statistical tests.
- Each figures and table should have a clear message
- Tables and figures should be understandable on their own, without reading the text
- See additional tips on preparing your results section in the “Tips For Preparing Your Results Section” handout, provided as a companion to this module.