We thank Drs. Joseph and Ananth (1) for their comments on our article (2). We did observe a bimodal distribution of
birth weights at 32–35 weeks’ gestation; however, it was not as distinct within this gestational age interval as it was at 28–31 weeks. While we did not specifically discuss the distribution of birth weight at 32–35 weeks, it was presented in figure 1 of our article (2, p. 61).

We agree that a consensus about the best method of excluding implausible birth weights has yet to be determined. We feel that obtaining unbiased estimates for very low gestational ages is especially crucial from a public health viewpoint. As Joseph and Ananth note, one approach would have been to use the fetal growth standards published by Alexander et al. (3) to exclude implausible gestational ages. However, we do not believe that these standards, which are derived from all US livebirths, are applicable to North Carolina non-Hispanic African Americans, because this population has considerably lower gestational-age-specific birth weight percentiles than those presented by Alexander et al. Instead, we presented findings from an analysis based on the Wilcox-Russell approach, which separates birth-weight distributions of all births into predominant and residual distributions (4, 5). Briefly, the predominant distribution is bell-shaped and can reflect the birth-weight distribution of full-term births, while the residual distribution represents births in the lower tail of the curve outside of the predominant distribution and is thus an indication of the proportion of small preterm births. This approach avoids misclassification of gestational age by using the frequency distribution of birth weight.

Our analysis showed that the residual distribution of birth weight increased from 4.6 percent to 5.3 percent for non-Hispanic African Americans in North Carolina from 1989 to 1999 (2). Thus, the proportion of small preterm births increased over this time period; these are the infants at highest risk for adverse health outcomes. This finding reaffirmed our impression that preterm delivery rates for non-Hispanic African Americans were not declining and that preterm birth among non-Hispanic African Americans remains a public health issue in North Carolina.

REFERENCES

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