Waiting as Good as Inducing Labor for IUGR

BY PATRICE WENDLING

CHICAGO — Monitoring and labor induction produce comparable neonatal outcome and operative delivery rates in women with suspected intrauterine growth restriction at term, based on the multicenter randomized DIGITAT study.

"It seems that both policies can be safely offered," principal investigator Dr. Kim Boers said at the annual meeting of the Society of Maternal-Fetal Medicine.

The Disproportionate Intrauterine Growth Intervention Trial at Term (DIGITAT) was conducted at 52 hospitals from a nationwide obstetric consortium in the Netherlands and involved 650 women with a singleton pregnancy with clinical suspicion of failure to thrive in utero after 36 weeks' gestation.

A total of 321 women were randomized to induction of labor within 48 hours and 329 to expectant monitoring according to a local protocol in an inpatient or outpatient setting. Cervical ripening with prostaglandins, osmotic

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DR. BOERS

cervical dilation, or digital sweeping of the membranes was optional.

The primary outcome was a composite adverse neonatal outcome of umbilical cord pH less than 7.1, a base excess less than –10, a 5-minute Apgar score of less than 7, and neonatal ICU (NICU) admission.

The composite outcome occurred in 17 cases in the induction group and in 20 cases in the expectant group, which was not statistically different, said Dr. Boers of Leiden (the Netherlands) University Medical Center.

NICU admissions were also similar at nine cases in the induction group vs. two in the expectant group. However, significantly more neonates in the induction group were admitted to high or medium care (155 cases vs. 118 cases), she said.

Infants born to the expectant group were significantly older and heavier at birth, with a mean gestational age of 277 days and a birth weight of 2,550 g vs. 266 days and 2,420 g in the induction group. There were no stillbirths or neonatal deaths in the trial, Dr. Boers reported. The use of induction did not significantly change the secondary outcome of operative delivery, which was reported in 45 cases in both groups.

During a discussion of the study, one attendee asked why obstetricians should wait to deliver a baby if IUGR was suspected. Dr. Boers responded, "If you are very keen on preventing every stillbirth, then you can induce and not raise cesarean rates, but I think there is a problem at 37 weeks because we saw more children admitted to high and medium care. So we are going deeper in debt to see which children benefit most from induction." ■

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Major Finding: Apgar scores and NICU admissions were not significantly different in IUGR pregnancies when women were induced vs. expectantly monitored.

Data Source: The multicenter randomized DIGITAT study of 650 women.

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