Five Study Findings May Alter Obstetric Practice

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KAILUA KONA, HAWAII — Five studies may change the way physicians think about prolonged premature rupture of membranes, perinatal stroke in the fetus, and other topics, Dr. Michael A. Belfort said at a conference on obstetrics, gynecology, perinatal medicine, neonatology, and the law.

He delineated the following areas in which obstetric practices could change because of these studies.

PPROM

If a pregnant woman with prolonged premature rupture of membranes (PPROM) reaches 34 weeks' gestation, it's probably in the mother's and the baby's best interests to deliver the baby rather than continue expectant management, according to a single-institution observational study (Obstet. Gynecol. 2005;105:12-7).

The investigators studied 430 pregnancies in 1998-2000 with PPROM and 24-36 weeks' gestation to determine optimal delivery time. Infants were delivered after reaching maturity (34 weeks or later) or after the development of chorioamnionitis, active labor, fetal compromise, or phosphatidylglycerol in vaginal pools.

Composite scores for neonatal morbidity suggested that there is limited benefit to continuing expectant management after 34 weeks in women with PPROM. Although this was not a randomized, controlled trial, physicians should seriously consider delivering these babies before 35 weeks' gestation to avoid the risk of abruption, the sudden onset of infection, or other problems, said Dr. Belfort, professor of ob.gyn. at the University of Utah, Salt Lake City.

Perinatal Stroke

An analysis of data from the Kaiser Permanente system identified four major risk factors for perinatal arterial ischemic stroke (PAS), which is present in 50%-70% of fetuses with hemiplegic cerebral palsy, epilepsy, or cognitive impairment.

"Read this [report] and understand that it is possible for a baby to have a stroke in utero" even if clinicians did nothing wrong during pregnancy or delivery, he said at the meeting sponsored by Boston University.

Two independent investigators reviewed 1,970 cases, compared them with three matched controls per case, and conducted multivariate analyses for risk factors. They found a rate of PAS of 20 per 100,000 live-born infants (JAMA 2005;293:723-9).

The four major risk factors for PAS were a history of infertility (with the risk perhaps related to the use of infertility drugs), preeclampsia, chorioamnionitis, and PPROM lasting longer than 18 hours. To defend against a lawsuit related to a bad outcome in a baby with PAS, look at the records to see if these risk factors were present, he suggested.

Trial of Labor

A 4-year observational study of 45,988 pregnant women with a prior cesarean section who underwent either a trial of labor or elective C-section answered an important question about the risks of inducing labor with Pitocin (synthetic oxytocin) that had been left hanging by previous studies of vaginal births after cesarean section.

Inducing labor significantly increased the risk of uterine rupture and rate of perinatal complications, the investigators found (N. Engl. J. Med. 2004;351:2581-9). Keep that in mind when counseling patients, he suggested.

Suctioning

A randomized, controlled study of 2,514 infants with meconium called into question the routine intrapartum practice of oropharyngeal suctioning.

Routine intrapartum suctioning did not prevent meconium aspiration syndrome, and in rare cases it traumatized the nasopharynx or caused a cardiac arrythmia (Lancet 2004;364:597-602). Recommendations for routine intrapartum suctioning should be revised, Dr. Belfort said.

Herpes

A metaanalysis of five randomized, controlled trials involving 799 pregnant women with herpes simplex virus found that giving acyclovir therapy beginning at 36 weeks' gestation reduced herpes recurrences at delivery, viral load, symptomatic shedding, and the need for a C-section (Obstet. Gynecol. 2003;102:1396-403).

"This is hard evidence, in my mind at least, that this is the standard of care now for women with herpes," he said. ■