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NJPA
New Jersey Perinatal Associates
Compassionate Care. Clinical Excellence.

MFM Newsletter

In this newsletter…

Elective Induction of Labor at Term

Historically, elective induction of labor has been regarded as harmful with a possible increased risk of cesarean delivery and worse perinatal outcomes compared to spontaneous labor. Recent observational cohort data suggested that women undergoing induction of labor had similar or even lower rates of cesarean delivery when compared to those women managed expectantly. The need for a randomized trial investigating this subject was very evident.

In August of this year, the results of a large randomized trial (named ARRIVE) that compared induction of labor at term versus expectant management in low-risk nulliparous women at 39 weeks of gestation were published in the New England Journal of Medicine. The primary outcome of this study was a composite of perinatal mortality or severe neonatal morbidity with rates of cesarean delivery as the secondary outcome. The study was conducted by the Eunice Kennedy Shriver National Institute of Child Health and Human Development Maternal-Fetal Medicine Units Network from March 2014 to August 2017. The investigators' hypothesis was that elective induction of labor at 39 weeks of gestation, compared with expectant management among low-risk nulliparous women, reduces the risk of a composite outcome of perinatal mortality or severe neonatal morbidity.

In this newsletter, we summarize the key findings of this large randomized trial as well as ACOG's clinical guidance for their integration.

Key Findings of the ARRIVE trial

- The trial included 6,106 women
- It was conducted in 41 facilities in the United States (combination of University and Community Hospitals)
- Greater than 94% of women adhered to their assigned protocol
- Greater than 62% of women in each group had a Bishop score of < 5 at time of randomization
- No statistical difference in the primary composite outcome of perinatal mortality and severe perinatal morbidity was noted
- The cesarean delivery rate was noted to be significantly lower in the induction of labor group (18.6% vs. 22.2%)
- A significantly lower rate in the induction group of gestational hypertension and preeclampsia (9.1% vs. 14.1%) was noted
- The study authors suggest that policies aimed at the avoidance of elective labor induction among low-risk nulliparous women at 39 weeks of gestation are unlikely to reduce the rate of cesarean delivery

- ACOG states that it is reasonable for obstetricians and health care facilities to offer elective induction of labor to low-risk nulliparous women at 39 weeks of gestation
- However, consideration for enactment of this elective induction intervention should also take into account the values and preferences of the pregnant woman and the resources available (including personnel/staffing and longer lengths of stay on labor and delivery)
- It is also critical that personnel and facilities coordinate policies related to the offering of elective induction of labor
- Additional studies are needed to assess cost effectiveness and a secondary-analysis from this trial is planned to assess impact on health care expenditures

References

Society for Maternal-Fetal Medicine statement on the ARRIVE trial (in press)

Grobman WA, et al. Labor induction versus expectant management in low-risk nulliparous women. N Engl J Med 2018;379:513-23

ACOG Practice Advisory: Clinical guidance for integration of the findings of the ARRIVE trial. August, 2018 (Endorsed by SMFM)

Please note that New Jersey Perinatal Associates (NJPA) has developed these best practice recommendations based on a review of current literature and expert opinion. They are not intended to establish standards or absolute requirements and these recommendations do not guarantee a specific outcome. All recommendations and best practices should be considered in the context of each patient's individual circumstances and clinical evaluation.

Zika Virus and Pregnancy

Recent updates from the CDC

Visit our website at:

www.njperinatal.com

CDC Zika Web Resources

https://www.cdc.gov/pregnancy/zika/women-and-their-partners.html

The CDC recommends precautions for women and their partners thinking about pregnancy to protect themselves from Zika virus infection around the time of pregnancy.

Zika continues to be a problem in many parts of the world. There is no vaccine to prevent infection. Zika can be passed from a pregnant woman to her fetus. Infection during pregnancy can cause certain birth defects. Your decision to delay or cancel travel is personal and complex. In making this decision, consider your travel destination and your ability to protect yourself from mosquito bites.

Couples should consider waiting to get pregnant if they live in or travel to an area with risk of Zika infection. If only the male partner travels to an area with risk of Zika, the couple should use condoms or not have sex for at least 3 months after the male partner returns, even if he doesn't have symptoms. If only the female partner travels to an area with risk of Zika, the couple should use condoms or not have sex for at least 2 months. If both partners travel, the couple should use condoms or not have sex for at least 3 months. The timeframes that men and women should consider waiting are different because Zika virus can stay in semen longer than in other body fluids.

Talk to your doctor or other healthcare provider before traveling to areas with risk of Zika, take steps to prevent mosquito bites and prevent sexual transmission of the Zika virus.

Meet our perinatologist…

Dom Terrone, MD

Dr. Terrone graduated from the University of Medicine and Dentistry of New Jersey and completed his residency in obstetrics and gynecology at Saint Barnabas Medical Center in New Jersey.

He completed his fellowship in maternal-fetal medicine and his Masters Degree of Science at the University of Mississippi in Jackson. Dr. Terrone's research interests include fetal therapy and preterm birth.

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