Perinatology

PS-309

PERINATAL COUNSELLING IN EXPECTED EXTREME PREMATURITY IN THE NETHERLANDS: CURRENT AND IDEAL PRACTICE AMONGST PERINATAL AND NEONATAL PROFESSIONALS

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10.1136/archdischild-2014-307384.608

Background and aims In the updated (2010) Dutch national guideline “perinatal practice in extremely premature delivery”, the gestational age (GA) at which resuscitation can be offered was lowered from 25⁺ weeks to 24⁺ weeks. Informed consent of the parents is required, however adequate prenatal counselling is not defined. We aimed to invent current and ideal counselling practice amongst professionals.

Methods Online questionnaire regarding current and ideal prenatal counselling (expected GA 24⁺ weeks), completed by neonatologists and obstetricians from all tertiary centres in the Netherlands.

Results 120 questionnaires were returned (response rate 60%). Almost everybody (93%¹ vs 98%²) agreed with shared-decision making as an ideal model for counselling parents whether or not to initiate active care. A majority prefers recommendation of active care at 24 weeks GA, but comfort care on parental request is acceptable (58%¹ vs 49%²). A minority prefers recommendation of comfort care and active care only on parental request (11%¹ vs 23%²). Current factors making it less likely to recommend active care at 24 weeks GA: dysmaturity (92%¹ vs 76%²) and additional congenital anomalies (99%¹ vs 98%²).

There were differences in the preferential GA for certain interventions, the majority (58%) of neonatologists mentions chest compressions are justified above 26⁺ weeks GA and 28.3% above 25⁺ weeks GA. Obstetricians give earlier margins: either above 25⁺ weeks GA (40%) or above 24⁺ weeks GA (40%).

Conclusions We observed only partial consensus on current and ideal prenatal counselling. Further discussion ideally results in a consensus-based guideline.

¹ = neonatologists ² = obstetricians.

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IMMEDIATE DELIVERY VERSUS EXPECTANT CARE IN WOMEN WITH PRETERM PRELABOUR RUPTURE OF THE MEMBRANES CLOSE TO TERM (PPROMT): A MULTI-CENTRE RANDOMISED CONTROLLED TRIAL

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10.1136/archdischild-2014-307384.609

Background Preterm prelabour rupture of membranes (PPROM) is the cause of 40% of all preterm births. Best practice for women who rupture their membranes preterm is not known. The aim of this study is to determine whether immediate delivery or expectant management of women with PPRM at 34–

36⁶ weeks gestation is associated with less neonatal and/or maternal morbidity.

Methods The PPRM Trial is a large, international, multi-centre, randomised controlled trial with 1835 recruits from 65 centres in 11 countries. The primary study outcome is the incidence of neonatal sepsis. Secondary outcomes include severe neonatal morbidity/mortality (sepsis, positive pressure ventilation >24 h or death), perinatal mortality, neonatal respiratory distress syndrome, mode of delivery and duration of hospitalisation for mothers and infants.

Results The trial finished in December 2013, 923 women were randomised to receive early delivery and 912 expectant management. 52 (2.8%) infants had sepsis. 134 (7.3%) had severe neonatal morbidity/mortality, including 6 (0.3%) deaths and 93 (5%) ventilation >24 h. 123 (6.7%) had Respiratory Distress Syndrome. 408 (22.2%) were born by caesarean section. Length of stay (median (IQR)) was 5 (4–8) days for mothers and 5 (3–9) days for infants. Analysis by intention to treat will be presented.

Conclusions There is a significant rate of neonatal and maternal morbidity after maternal PPRM at 34–36⁶. If it can be demonstrated that either early planned birth or expectant management in this clinical situation is associated with less neonatal and/or maternal morbidity this will change current international practice.

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ASSOCIATION OF CAFFEINE CONSUMPTION WITH PRETERM BIRTH AND LOW BIRTHWEIGHT IN RIBEIRÃO PRETO, SÃO PAULO, BRAZIL

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10.1136/archdischild-2014-307384.610

Background and aims The association between caffeine consumption and adverse perinatal outcomes is still controversial. This study aimed to evaluate the association between caffeine consumption during pregnancy and preterm birth (PT, <37 weeks) and low birthweight (LBW, <2500 g) in the birth cohort of Ribeirão Preto, Brazil in 2010.

Methods A convenience cohort of 1370 pregnant women living in the city was evaluated between 22–25 weeks of gestation and their respective newborns. Standardised questionnaires were applied during pregnancy and soon after birth and anthropometric information of the newborn was obtained from medical records. The independent variable was the consumption of caffeine during pregnancy (high consumption ≥300 mg caffeine/day), considering the informed consumption of coffee, tea, cola and chocolate milk. The dependent variables were LBW and PT. Logistic regression was used to evaluate the association of caffeine consumption and PT and LBW, adjusting for maternal biological and sociodemographic variables.

Results Caffeine intake in this cohort was 96.2%, being 5.6% of high consumption. In unadjusted analysis, women who consumed caffeine ≥300 mg/day had twice the risk of LBW (OR = 2.82; confidence interval 95%, CI95% 1.49–5.34) than those who consumed <300 mg/day, but no association with PT (OR = 1.88; CI95% 0.98–3.59) was observed. After adjustment, the risk of LBW was three times higher (OR = 3.35; CI95% 1.29–8.66) and there was no association with PT (OR = 1.19; CI95% 0.48–2.86).