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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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 23+10 weeks GA to 24+10 weeks GA. 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+10 weeks GA), 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 (98%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+0 weeks GA and 28.3% above 25+0 weeks GA. Obstetricians give earlier marges: either above 25+10 weeks GA (40%) or above 24+10 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.

PS-310  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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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 PPROM at 34–36 weeks gestation is associated with less neonatal and/or maternal morbidity.

Methods The PPROMT Trial is a large, international, multicentre, 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, perinatal 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 PPROM at 34–36 weeks gestation. 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.