Unadjusted OR for maternal adverse outcomes

	I-D≤2min N(%)	I-D>2min N(%)	RR	95% CI	p
Composite maternal outcome	39 (36.1%)	159 (23.2%)	1.9	1.6-2.2	<0.01
Intraoperative transfusion	7 (6.5%)	12 (1.8%)	3.9	1.6-9.2	<0.01
Uterine artery ligation	9 (8.3%)	10 (1.5%)	6.1	2.7-13.9	<0.01
Broad ligament hematoma	4 (3.7%)	3 (0.4%)	8.7	2.1-37.2	<0.01

349 Maternal and neonatal outcomes after antenatal corticosteroid administration for PPROM at 32-33 6/7 weeks gestational age

Lili Sheibani[1], Alex Fong[1], Dana Henry[3], Mary Norton[3], Yen Truong[4], Adanna Anyikam[5], Louise Laurent[5], Rashmi Rao[2], Deborah Wing[1]
[1]University of California, Irvine, Obstetrics and Gynecology, Long Beach, CA, [2]University of California, Los Angeles, Obstetrics and Gynecology, Los Angeles, CA, [3]University of California, San Francisco, Obstetrics and Gynecology, San Francisco, CA, [4]University of California, Davis, Obstetrics and Gynecology, Sacramento, CA, [5]University of California, San Diego, Obstetrics and Gynecology, San Diego, CA

OBJECTIVE: Preterm premature rupture of membranes (PPROM) precedes many preterm deliveries and most agree with expectant management between 24-34 weeks' gestation and with the administration of corticosteroids. However, the upper and lower limits of gestational age (GA) for this intervention remain controversial. The aim of the study was to compare the maternal and neonatal outcomes with and without administration of corticosteroids for PPROM from 32-33 6/7 weeks.

STUDY DESIGN: We conducted a retrospective cohort study in the five institutions of the University of California Fetal Consortium (UCfC). We searched all available charts from 2004 to 2014 of singleton pregnancies with PPROM at 32-33 6/7 weeks' gestation. Subjects who received antenatal corticosteroids were compared with those who did not. Major congenital anomalies were excluded.

RESULTS: There were 141 women with PPROM at 32-33 6/7 weeks in the cohort, 119 received corticosteroids. There were no differences between groups in maternal age, race/ethnicity, or the presence of diabetes or hypertension. There was no difference in the latency period between the steroid and no steroid groups (2d (0-11) vs 1d (0-14); p=0.47). The GA at delivery in the steroids group was 33 1/7 wks. vs. 33 4/7 wks. with no steroids (p=0.02). There was a trend toward a higher prevalence of chorioamnionitis (14% vs. 4%, p=0.16; aOR 4.82 (0.54-42.65)) and lower prevalence of respiratory distress syndrome (RDS) (33% vs. 62%; p=0.13, aOR 0.36 (0.10-1.33)) in those subjects who received corticosteroids between 32-34 weeks when adjusted for latency period. There was no difference in prevalence of endometritis in the two groups.

CONCLUSION: Our data suggest a higher rate of chorioamnionitis and lower rate of RDS with administration of corticosteroids in patients with PPROM at 32-34 wks. A larger prospective study is needed to determine if the benefit of corticosteroids outweighs the potential risks in those with PPROM at this gestational age.

Maternal and neonatal outcomes with and without steroid administration at 32-33 6/7 weeks for PPROM

Outcome	Steroids received n=119	No steroids received n=22	OR (95% CI)	p-value
GA at admission (weeks)	32.73 ± 0.56	33.03 ± 0.54	_	0.02
GA at delivery (weeks)	33.12 ± 0.59	33.46 ± 0.76	_	0.02
Latency period (days)	2 (0-11)	1 (0-14)	_	0.47
Chorioamnionitis*	16/118 (13.6%)	1/23 (4.3%)	4.82 (0.54-42.65)	0.16
5-minute Apgar	8 (1-10)	9 (0-9)	_	0.59
RDS*	16/48 (33.3%)	8/13 (61.5%)	0.36 (0.10-1.33)	0.13

Expressed as mean (± std deviation) and median (range). Significance calculated via Chi-squared, Fisher's exact, Student's t, Mann-Whitney U tests. Kurtosis of +/- 2 used for determining normality of distribution

*Adjusted via regression analysis for latency period

350 Amniocentesis does not increase the risk of miscarriage in patients with positive prenatal screening

Linda Cowan[1], Mary Norton[2], Sara Goldman[3], Monica Flessel[3], Laura Jelliffe-Pawlowski[4], Dena Towner[5], Robert Currier[3]
[1]David Geffin School of Medicine at UCLA, Dept of Obstetrics and Gynecology, Los Angeles, CA, [2]University of California San Francisco, Dept of Obstetrics, Gynecology, and Reproductive Sciences, San Francisco, CA, [3]California Department of Public Health, Genetic Disease Screening Program, Sacramento, CA, [4]University of California San Francisco, Dept of Epidemiology and Biostatistics, San Francisco, CA, [5]John A Burns School of Medicine, Dept of Obstetrics, Gynecology, and Women's Health, Manoa, HI

OBJECTIVE: To estimate the risk of pregnancy loss among prenatal screen positive singleton pregnancies after mid-trimester amniocentesis by experienced practitioners.

STUDY DESIGN: Screen positive patients in the California Prenatal Screening Program are offered referral to Prenatal Diagnosis Centers (PDC), where they are offered genetic counseling, detailed anatomic ultrasound, and amniocentesis. Pregnancy losses were ascertained via outcome of pregnancy surveys sent to the providers of all screen positive patients. Singleton pregnancies having amniocentesis were compared with those that declined. Cases with chromosome abnormalities or structural birth defects based on PDC visit reports, outcome survey, or California Chromosome Registry report were excluded. Cases that were screen positive for neural tube defects were also excluded based on the difference in amniocentesis acceptance rates in this population. Two-sided confidence intervals for the loss rates in the two groups were calculated.

RESULTS: After exclusions, there were 11,478 amniocenteses and 14,475 declines who were screened between April 2009 and December 2012. In the amniocentesis group, there were 80 fetal losses (0.70%, 95% CI 0.54%-0.85%). In the decline group, there were 117 fetal losses (0.81%, 95% CI 0.66%-0.95%). These rates were not significantly different (p=0.84). The probability that any increase in loss rate associated with amniocentesis, if present, is <1/1000 is 0.82, and that any increase is <1/500 is 0.97.

CONCLUSION: The risk of pregnancy loss in a singleton, prenatal screen positive pregnancy after amniocentesis by an experienced practitioner is 1/143 (0.70%), which is equal to the loss rate when amniocentesis is declined in these high-risk pregnancies. There is no evidence that amniocentesis by an experienced practitioner increases the risk of pregnancy loss. The increase in pregnancy loss after amniocentesis is smaller than current estimates.

Outcome data and miscarriage rates among prenatal screen positive women without chromosome abnormalities or structural birth defects

	Amniocentesis	Decline
Population	11,478	14,475
Fetal Demise < 20 weeks	31	29
Fetal Demise >= 20 weeks	49	88
Total Demise at all GA	80	117
Rate	0.70%	0.81%
95% Confidence Interval	0.54%-0.85%	0.66%-0.95%
	Combined	
Rate of Pregnancy Loss	0.76%	
95% Confidence Interval	0.55%-0.97%	
	Z-score	p-value
Increase Loss Rate < 1:1000	0.9219	0.8217
Increase Loss Rate < 1:500	1.8437	0.9674