<1000 deliveries per year broadly distributed over the patient population. Rates of morbidity in centers with ≥1000 deliveries have also increased. These findings suggest that maternal safety improvements are necessary at all centers regardless of volume.

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CORRECTIONS

October 2016 (vol. 215, no. 4, page B6)

One sentence should be removed from the article “The use of chromosomal microarray for prenatal diagnosis” (Consult Series #41, Society for Maternal-Fetal Medicine, October 2016).

Under the heading “When is it appropriate to perform just a karyotype? Is it necessary to do a karyotype if a microarray is being done?” (page B6, column 2), the last sentence of the first paragraph should be deleted: “We recommend against the use of CMA as a first-line test to evaluate first-trimester pregnancy losses due to limited data (GRADE 1C).”

The Summary of Recommendations table on page B8 already reflects this correction, which has been made to the text of the article at ajog.org as well.

August 2016 (vol. 215, no. 2, page B14)

In an SMFM Statement, the following replaces the first item under “SMFM recommendations” (page B14, column 2):

1. In women with a singleton pregnancy between 34 weeks 0 days and 36 weeks 6 days of gestation who are at high risk for preterm birth within the next 7 days (but before 37 weeks of gestation), we recommend treatment with betamethasone (2 doses of 12 mg intra-muscularly 24 hours apart).

The text as published erroneously indicated that a single betamethasone dose was recommended. The online article at ajog.org has been corrected.