of PPH before invasive procedures. Instead, we suggest that high-quality implementation research is needed to determine the most effective programmatic and health care delivery strategies on UBT introduction and use. Based on the findings of our study, we consider that any UBTs, including Bakri balloons and condom-catheter UBTs, can be used for the management of severe PPH before surgical or radiological interventions.

Third, the RCTs conducted by Dumont et al[3] and Anger et al[4] that concluded that condom-catheter UBTs did not reduce the risk of PPH-related maternal death and/or invasive procedures had multiple methodological problems that may have biased their results.

Fourth, despite the differences between Bakri balloons and condom-catheter UBTs, both are similarly inserted into the uterus and filled with fluid, and both tamponade uterine bleeding when the balloon adapts to the configuration of the uterine cavity. Thereby, in accordance with core principles of systematic reviews and meta-analyses, it is clearly valid to pool the results of studies that assessed different types of balloons to obtain pooled estimates of the efficacy and effectiveness of UBT for treating PPH.

Finally, it is false that condoms explode after being filled with more than 250−300 mL. A recent in vitro study[5] concluded that intraluminal pressure of condoms remains stable with instillation of saline between 300 mL and 1200 mL, a volume that has also been reported in in vivo studies. Importantly, in this study, no condoms burst with volumes ≤5000 mL of saline. ■

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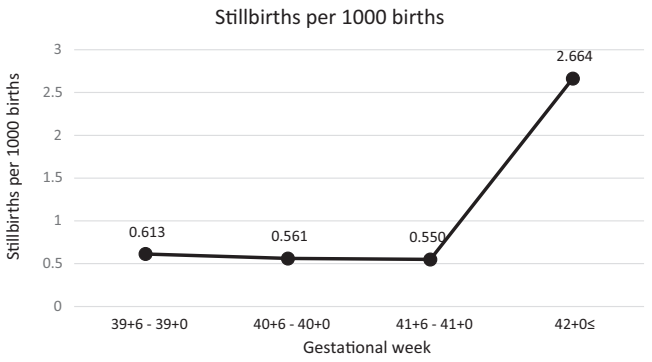
The impact of induction of labor at 39 weeks on the incidence of stillbirth in low-risk women

Check for updates

TO THE EDITORS: We read with interest the Research Letter by Po' et al.[1] The study described the stillbirth rate per week in the United States from the 39th gestational week onward in low-risk women. The purpose was to determine the impact of induction of labor at 39 weeks on the stillbirth rate in low-risk women. The impetus for the study was based on the results of the ARRIVE trial.[2]

The ARRIVE trial, first published in August 2018, was designed to determine whether induction of labor at 39 weeks gestation of low-risk nulliparous women reduces the risk of a composite outcome of perinatal death or severe neonatal complications (the primary outcome) as compared with expectant management.[2] The authors determined that labor induction did not quite significantly decrease the primary outcome (4.3% in the induction group vs 5.4% in the expectant management group; relative risk, 0.80; 95% confidence interval, 0.64−1.00; P=.049, statistical significance adjustment to <.046) and therefore concluded that a policy of induction of low-risk nulliparous women at 39 weeks was reasonable.

FIGURE
Stillbirth rates per gestation week



Data from Po' et al.[1]

Peleg. Letter to the editor. Am J Obstet Gynecol 2020.

Po' et al[1] assume that the same conclusions are valid for all low-risk women, not only nulliparous women. The stillbirth data presented as differentiated from the prospective stillbirth rate proposed by Po' et al is shown in the Figure. In other words, the "background" risk of stillbirth remains unchanged up to the end of 41 weeks gestation. Similar results would be expected if the variable was hypertension, eclampsia, oligohydramnios, meconium aspiration, placental abruption, shoulder dystocia, among others.

We believe it is unjustified to extrapolate the results of the ARRIVE trial to all low-risk women. Before induction of labor at 39 weeks gestation becomes routine, we suggest that more research be published with transparency of data. Until that time, we remain disinclined to offer induction of labor as standard of care at 39 weeks to low-risk women, nulliparous or parous. ■

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The authors report no conflict of interest.

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REPLY

Check for updates

We thank Drs Peleg and Warsof for their letter regarding our manuscript entitled "The impact of induction of labor at 39 weeks in low-risk women on the incidence of stillbirth." We acknowledge that the background risk of stillbirth increases after 41 weeks gestation. This is applicable to women regardless of their parity.

In light of data from the ARRIVE trial, there is compelling evidence for maternal benefit for induction of labor at 39 weeks gestation, including the decreased risk of cesarean delivery. We recognize that the ARRIVE trial included only low-risk nulliparous women. Other studies have shown similar results in low-risk multiparous women.[1] In addition, there is some evidence of worsening neonatal outcome in late-term pregnancy in parous women. Our data add to the existing evidence that supports 39-week induction of labor in low-risk women by also eliminating the risk for stillbirth throughout later gestational ages. Some data show that the widespread adoption of the "39-week rule" in the early 2010s led to an increase in the rate of term stillbirths, because infants who would have delivered possibly a bit earlier (eg, at 37 or 38 weeks gestation) were instead being delivered at 39 weeks.[2]

A recent survey of women in the third trimester of pregnancy suggests that almost one-half are interested in induction of labor before their due date (ie, 39 weeks gestation), even without maternal or fetal indications. This indication should be called "induction for 39 weeks gestation."[3] ■

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