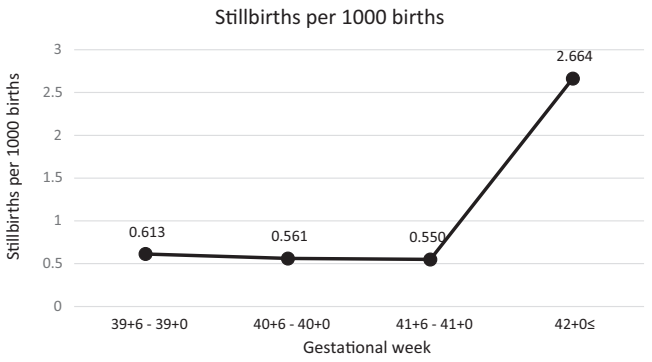
FIGURE
Stillbirth rates per gestation week



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. ■

David Peleg, MD
Departments of Obstetrics and Gynecology
Ziv Medical Center
Azrieli Faculty of Medicine
Bar-Ilan University
Safed, Israel
david.p@ziv.health.gov.il

Steven L. Warsof, MD
Division of Maternal-Fetal Medicine
Eastern Virginia Medical School
Norfolk, VA

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] ■

Gaia Po', MD
Obstetrics and Gynecology Unit
Mother-Infant and Adult Department of Medical and Surgical Sciences
University of Modena and Reggio Emilia
Modena, Italy

Emily A. Oliver, MD
Vincenzo Berghella, MD
Division of Maternal-Fetal Medicine
Department of Obstetrics and Gynecology
Thomas Jefferson University Hospital
Philadelphia, PA
vincenzo.berghella@jefferson.edu

The authors report no conflict of interest.

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A critical appraisal of "Point-of-care HIV viral load in pregnant women without prenatal care: a cost-effectiveness analysis"

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TO THE EDITORS: On behalf of our Women's HIV Program at Northwestern University, we applaud Avram et al[1] in tackling an important issue in the perinatal management of pregnant women living with HIV. However, we are writing to express our content and methodologic concerns with your manuscript.

We wish to raise a specific concern with the methods used in the decision analysis. The point-of-care-testing arm carries branches that indicate the potential for false negatives and a higher risk of mother-to-child transmission of HIV (MTCT) through undergoing labor that does not exist in the cesarean arm. Unless the point-of-care test is truly 100% sensitive in real-world clinical use, the point-of-care branch will always allow for false negatives and more MTCT than the universal cesarean section arm. Therefore, the point-of-care-testing arm carries all of the risks inherent in a screening strategy that are not present in a policy of universal cesarean delivery. When this type of imbalance is present in a decision tree, "[…] then either the tree is not a valid model of the clinical problem or the clinical problem does not require a decision analysis."[2]

An important consideration is the extrapolation of the findings of Avram et al[1] to clinical practice. In resource-rich areas, such as the United States, the expansion of public health infrastructure (eg, expedited HIV viral load testing, specialized perinatal HIV consultation, expanded case management) is more likely to yield benefits in maternal and child health than investing in point-of-care HIV viral load screening tests with inherently inadequate test characteristics. A successful example of this infrastructure is Illinois's Perinatal HIV Hotline.[3]

The potential ramifications of interpreting the decision analysis outside of the United States, particularly in the global South where the majority of MTCT occurs and where the proposed point-of-care HIV viral load test the authors describe would likely be used, are even more important to consider.[4] The increase in maternal morbidity and deaths that are associated with cesarean delivery, particularly in low-to-middle-income countries, must be considered when contextualizing these data in other settings, because the probabilities that were used for the decision analysis were significantly lower than those published from low-to-middle-income countries.[5]

Finally, the article's language is not consistent with contemporary recommendations for patient-centered nomenclature. The use of "HIV-infected women" is a stigmatizing term and should be replaced with "women living with HIV" or "persons living with HIV."[6,7] Failing to use "people-first language" within biomedical publications disempowers individuals living with a chronic, treatable condition. As healthcare providers, it is our duty to support our patients through medically appropriate, preferred language. We hope the Editorial Board of the American Journal of Obstetrics and Gynecology will consider expanding the author guidelines on "Use of inclusive language" to also support the use of nonstigmatizing, person-first language in the future. ■

Ashish Premkumar, MD
Irina Cassimatis, MD
Saba H. Berhie, MD
Department of Obstetrics and Gynecology
Feinberg School of Medicine
Northwestern University
Chicago, IL
ashish.premkumar@northwestern.edu

The authors report no conflict of interest.

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