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Planned Early Delivery or Expectant Management for Late Preterm Pre-eclampsia (PHOENIX): A Randomized Controlled Trial — Source link

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1 Planned early delivery or expectant management for late preterm pre-eclampsia: a randomised
2 controlled trial (PHOENIX trial).

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29 **Summary**

30 *Background*

31 In women with late preterm pre-eclampsia between 34 and 37 weeks' gestation the optimal time to
32 initiate delivery is unclear, as limitation of maternal disease progression needs to be balanced
33 against complications for the infant related to ongoing expectant management or planned early
34 delivery.

35

36 *Methods*

37 In this UK parallel-group, non-masked, multi-centre, randomised controlled trial, we compared
38 planned delivery against expectant management (usual care) with individual randomisation in
39 women with late preterm pre-eclampsia from 34 up to 37 weeks' gestation and a singleton or
40 dichorionic diamniotic twin pregnancy. The co-primary maternal outcome was a composite of
41 maternal morbidity with the addition of recorded systolic blood pressure ≥ 160 mmHg. The co-
42 primary perinatal outcome was a composite of perinatal deaths or neonatal unit admission up to
43 infant hospital discharge. Analyses were by intention to treat. The trial was prospectively registered
44 with the ISRCTN Registry, number 01879376.

45

46 *Findings*

47 Between 29 September 2014 and 10 December 2018, 901 women were recruited across 46
48 maternity units. 450 women (448 women and 471 infants analysed) were allocated to planned
49 delivery, and 451 women (451 women and 475 infants analysed) to expectant management. The
50 incidence of the co-primary maternal outcome was significantly lower in the planned delivery group
51 (64.7%) compared to the expectant management group (75.3%); adjusted risk ratio 0.86 (95% CI
52 0.79 to 0.94); $p < 0.01$. The incidence of the co-primary perinatal outcome was significantly higher in
53 the planned delivery group (41.8%) compared to the expectant management group (33.5%);
54 adjusted risk ratio 1.26 (95% CI 1.08 to 1.47); $p < 0.01$. There were nine serious adverse events in the
55 planned delivery group and twelve in the expectant management group.

56

57 *Interpretation*

58 There is strong evidence to suggest that planned delivery reduces maternal morbidity and severe
59 hypertension, with more neonatal unit admissions related to prematurity, but no indicators of
60 greater neonatal morbidity, compared to expectant management.