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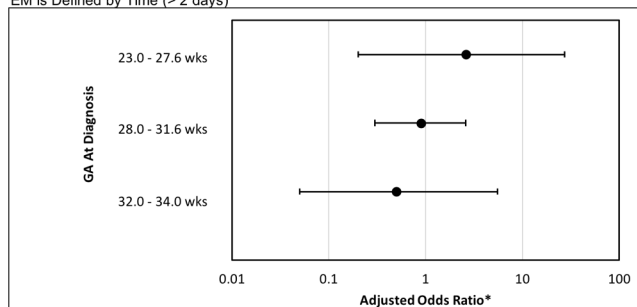
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Figure : Odds of Composite Neonatal Morbidity Stratified by Gestational Age at Diagnosis EM is Defined by Time (> 2 days)



*Odds Ratios Adjusted for GA at SPE diagnosis, ID is reference group ($p = 0.13$)

297 High-dose misoprostol with subsequent foley versus low-dose misoprostol with concurrent foley for cervical ripening

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OBJECTIVE: A prominent trial showed low-dose misoprostol with concurrent Foley for cervical ripening increased the likelihood of vaginal delivery and shortened the median time to delivery when compared to either method alone, prompting many institutions to adopt this protocol. Our study aimed to address differences in labor outcomes with low-dose misoprostol and concurrent Foley versus high-dose misoprostol and subsequent Foley.

STUDY DESIGN: This was a retrospective before-and-after study of nulliparous women with non-anomalous, term, singletons delivered at the University of California San Francisco (UCSF) in two separate two-year periods before and after changes in UCSF's IOL protocol. In May 2017, the term IOL protocol changed from 50-100 mcg PO every 4 hours with subsequent Foley to 25 mcg PO every 2 hours with concurrent Foley. The primary outcome was time from first misoprostol dose to delivery. The Kruskal-Wallis test was used to compare median values, and chi-squared tests were used to compare proportions.

RESULTS: 1,496 women met the inclusion criteria. Comparing the high-dose group ($n = 698$) to the low-dose group ($n = 798$), we found no statistically significant differences in time to delivery (29.1 vs 29.9 hr, $P = 0.689$), rate of cesarean delivery (30% vs 26%, $P = 0.086$), or cesarean delivery for fetal indications (11% vs 8%, $P = 0.145$). Among vaginal deliveries, there was similarly no difference in time to delivery (26.9 vs 27.0 hr, $P = 0.893$). Although the low-dose cohort had a lower cumulative misoprostol dose (100 mcg vs 150 mcg, $P < 0.001$), this group had a higher number of misoprostol administrations (4 vs 2, $P < 0.001$).

CONCLUSION: Protocols using high-dose misoprostol with subsequent Foley and low-dose misoprostol with concurrent Foley did not differ in time to delivery, time to vaginal delivery, or likelihood of vaginal delivery. In the absence of a superior clinical method for cervical ripening a shared-decision making model, incorporating patient preference, may be applied regarding timing of Foley catheter placement and dosing of misoprostol.

Table 2. Pregnancy outcomes.

	High-dose misoprostol (n = 698)	Low-dose misoprostol (n = 798)	P value
Time from first misoprostol to delivery (hours)	29.1 (20.5-41.7)	29.9 (20.1-40.5)	0.689
Cumulative misoprostol dose (mcg)	150 (50-250)	100 (50-150)	< 0.001
Total number of misoprostol administrations	2 (1-3)	4 (2-6)	< 0.001
Cesarean delivery for any indication	208 (30%)	206 (26%)	0.086
Cesarean delivery for fetal indication	74 (11%)	67 (8%)	0.145
Postpartum hemorrhage	74 (11%)	119 (15%)	0.013
Blood transfusion	41 (6%)	49 (6%)	0.829
Chorioamnionitis	70 (10%)	94 (12%)	0.280
Low Apgar score	29 (4%)	50 (6%)	0.067
NICU admission	117 (17%)	76 (10%)	< 0.001

Data presented as n (%) for categorical variables and median (interquartile range) for continuous variables with non-parametric distribution.

298 Assessing the need for subsequent pregnancy education at time of spontaneous preterm delivery

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OBJECTIVE: The strongest risk factor for preterm birth (PTB) is history of prior PTB. Despite interventions such as cerclage and 17 alpha-hydroxyprogesterone caproate (17 OHP-C), the rate of PTB has not significantly decreased. Lack of follow up postpartum (PP) visits and preconception counseling may be attributing to limited familiarity of PTB prevention. We sought to assess the knowledge of treatments and management for subsequent pregnancies in women with history of PTB.

STUDY DESIGN: We conducted a qualitative study using a confidential telephone survey of women who had a PTB between July 2016-March 2018 at a tertiary care center. Maternal and fetal indications that prompted iatrogenic preterm delivery were excluded. Recorded data was analyzed to assess the following: 1) knowledge of cerclage and/or 17 OHP-C, 2) PTB prevention counseling in immediate PP period, 3) contraceptive counseling in immediate PP period, and 4) interest in receiving education on PTB prevention.

RESULTS: Of 525 women who had spontaneous PTB, 70 agreed to participate in the survey. Twenty-three (33%) women had heard about 17 OHP-C and cerclage, though 11 (48%) of those women had already had a subsequent pregnancy with one or both of their use. Fifty-six (80%) women received immediate PP contraceptive counseling, however, only 19 (27%) women received immediate PP PTB prevention counseling. Fifty-two (74%) women reported they would have liked to receive PTB prevention counseling at time of their delivery. Forty-nine (70%) women reported they would be interested in receiving educational material if such become available. The most common reason provided for not wanting education or PTB prevention counseling was no longer desiring future pregnancy.

CONCLUSION: The majority of women with history of PTB are not aware of existing interventions to prevent PTB. Counseling in the immediate PP period after PTB is not frequently provided but is sought after by women. These findings suggest that there is a need to provide counseling and educational resources in the immediate PP period to women who have PTB and desire subsequent pregnancies.