Quoi de neuf en Obstétrique ?

Camille LE RAY

Maternité Port Royal, Paris
INSERM U953

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COCHIN BROCA HÔTEL-DIEU

Inserm
Institut national de la santé et de la recherche médicale

SFAR 2013

« Choisir … »

« À l'heure du choix, chacun est libre. » ***Georges Lucas***

« Le mauvais choix est l'absence de choix. » ***Amélie Nothomb***

« Choisir ! c'est l'éclair de l'intelligence. Hésitez-vous?.. tout est dit, vous vous trompez. » ***Honoré De Balzac***

« Toute la vie est une affaire de choix. Cela commence par : la tétine ou le téton ? Et cela s'achève par le chêne ou le sapin? » ***Pierre Desproges***

1. **Résultats d'EURO-PERISTAT**
2. **Evolution de l'âge maternel et conséquences obstétricales**
3. **Prévention de l'hémorragie du post-partum**
4. **Pessaire en prévention de la prématurité**

European Perinatal Health Report 2010

Projet EURO-PERISTAT

- Développer un système de monitoring européen des principaux indicateurs de santé périnatale
- Financé par European Public Health Program
- Méthodologie dirigée par INSERM U953 (J Zeitlin – B Blondel)

- Rapports précédents en 2000 et 2004
- Tous les pays membres + Islande, Norvège et Suisse
- Point faible de la France, seul pays avec Chypre à ne pas avoir de données issues de registre de naissances

Mortalité fœtale (≥28 SA) en 2004 et 2010

France : dernier rang pour les enfants morts-nés ≥28SA

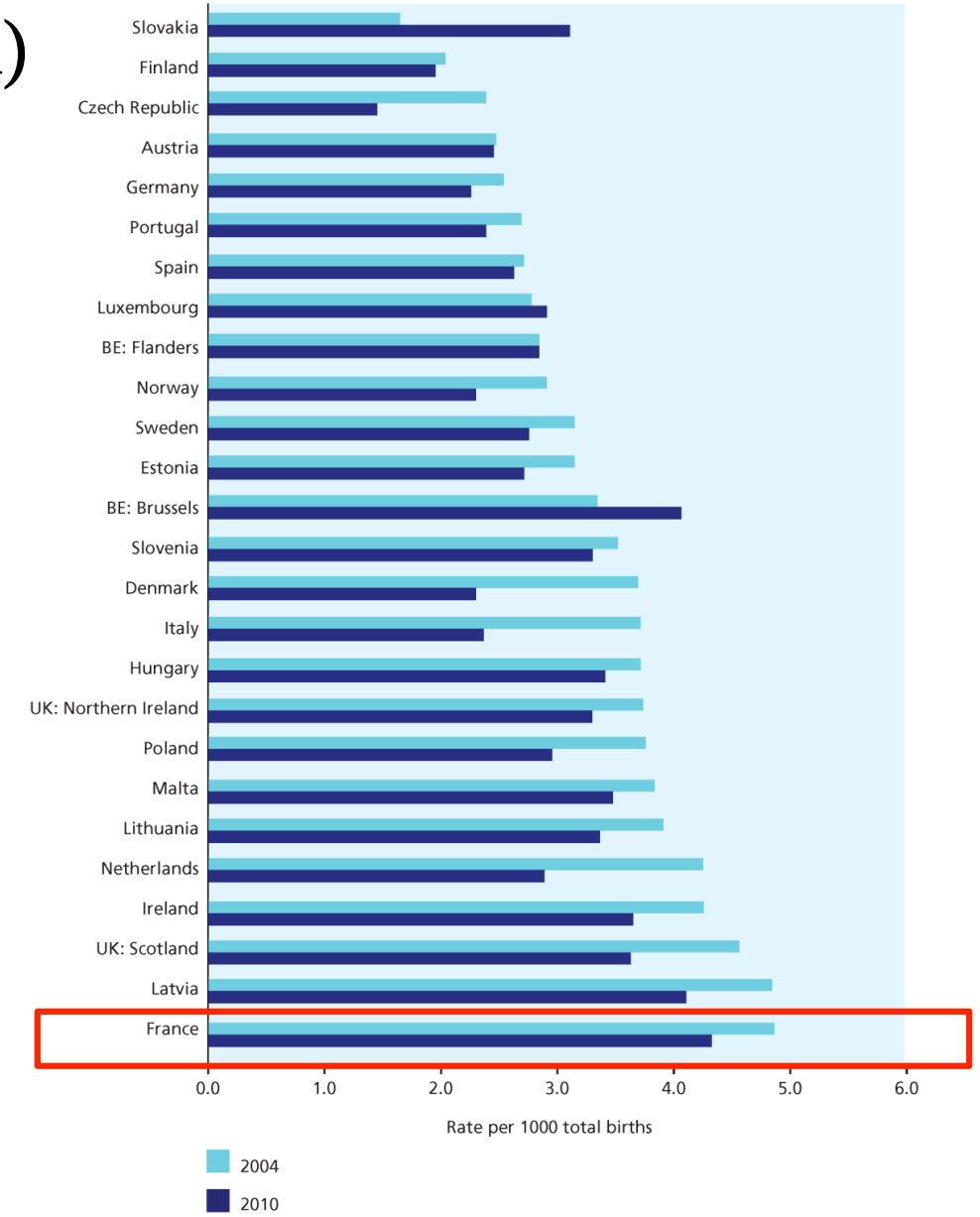
mais

-Collecte des morts nés différente selon les pays (exhaustivité ?)

- Inclusion des IMG (« politique » française très large)

-➔ 40 à 50% attribuable aux IMG

Figure 7.3 Comparison of fetal mortality rates at or after 28 weeks in 2004 and 20

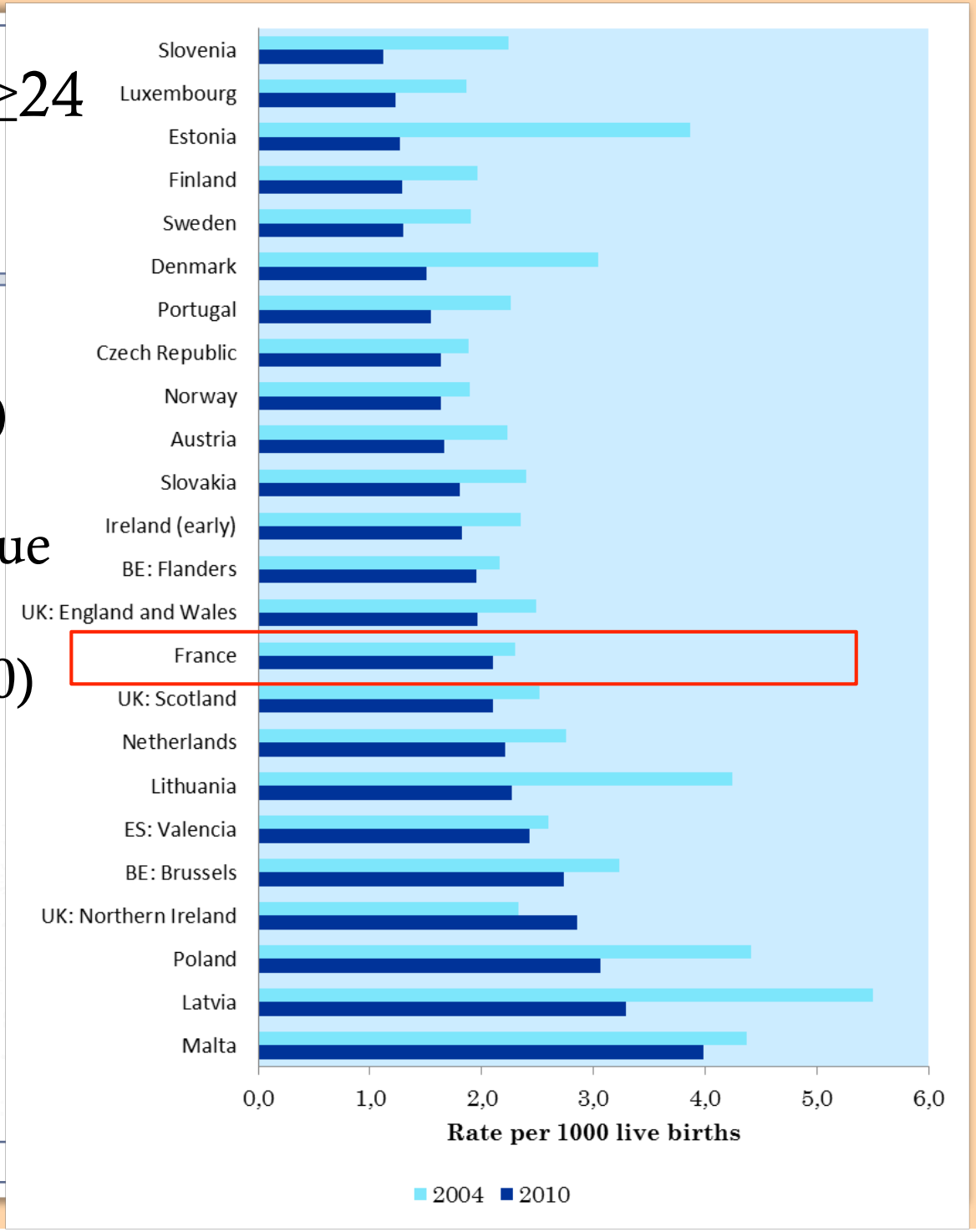


NOTE: Countries ranked by ascending fetal mortality rate at or after 28 weeks in 2004.

Mortalité néonatale (≥24 SA) en 2004 et 2010

2,1 pour 1000 (14ème rang)

Diminution moins forte que dans d'autres pays (-0,09% entre 2004 et 2010)

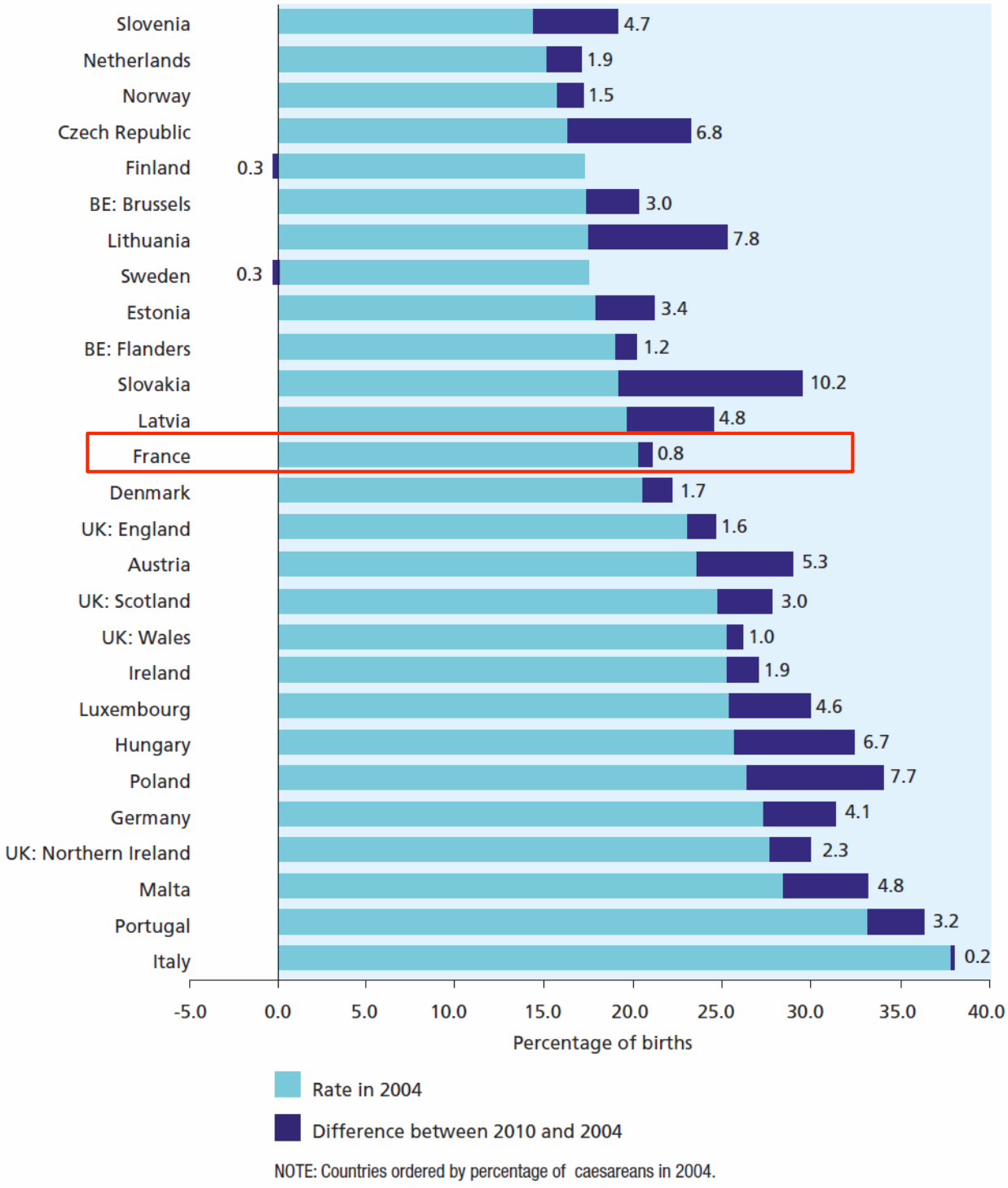


Taux de césarienne

Point fort pour la France (21%)

- Taux de césarienne plutôt stabilisé et bas

- Passage du 13ème au 7ème rang



Prématurité en 2010

En France, 6.6% des naissances vivantes

10ème rang mais … en hausse !

Evolution de la prématurité entre 2004 et 2010

Augmentation potentiellement attribuable à l'augmentation des facteurs de risque :

-Grossesse gémellaire

-Âge maternel


Gala
ÉVÉNEMENT
LAURENCE FERRA
RÉDACTRICE EN CHE
DE GAL
Beaut
Les 12 produits sta
de la rentr
ROBBIE WILLIAMS
L'album photo d'un
MARIAGE très rock
Christian Lacroix
LE COUTURIER SORT
DE SON SILENCE
MAMAN À 44 ANS
LAURENCE


VANITY FAIR
€1,90
MODA
PRINCIPESSA
PUNK
PICCOLI
FIORI
SANDRA
BULLOCK
& KATE
WINSLET
BENVENUTO OSCAR
MARITO ADDIO
ALESSANDRA
MASTRONARDI
LA SUORA INNAMORATA
BARBARA
DE ROSSI
QUANDO «BALLAVO»
TUTTA NUDA
ENRICO
MENTANA
ESCLUSIVO
Monica
BELLUCCI


HELLO
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IN HER OWN WO
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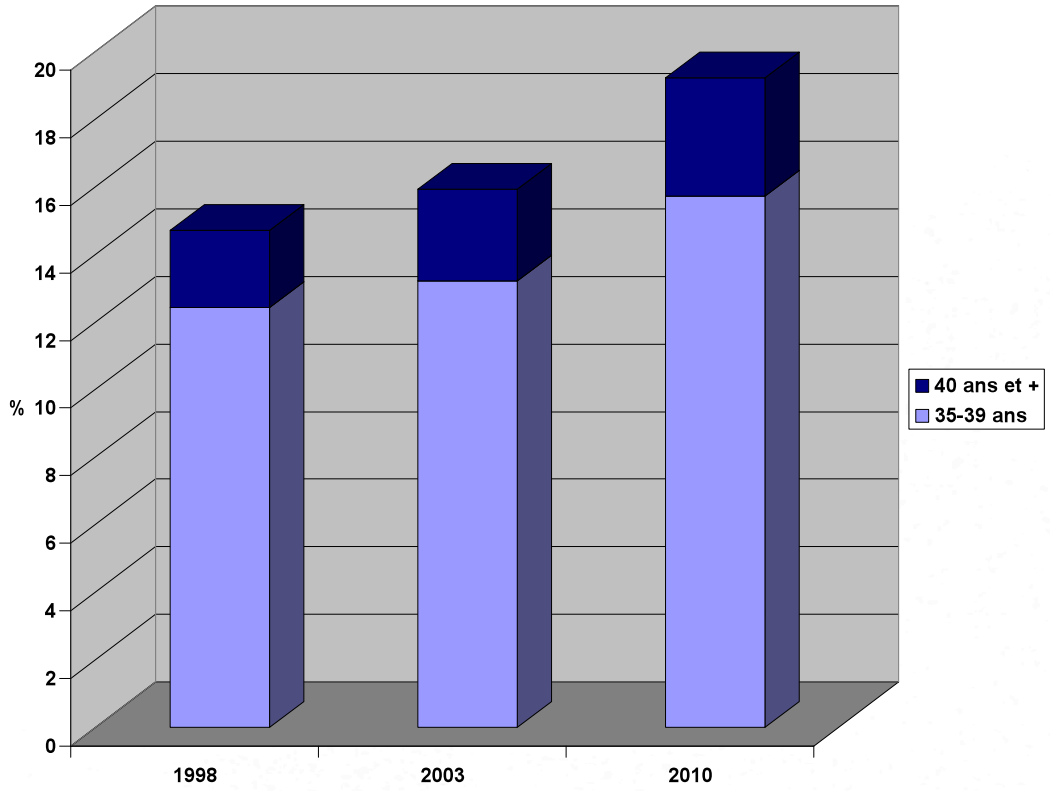
ACADEMY
MGM GRAND

Âge maternel à l'accouchement en France



Enquêtes nationales périnatales

Origine multifactorielle:

- Transformation des normes sociales *(allongement de la durée des études, plans de carrière ambitieux, unions tardives, familles recomposées)*

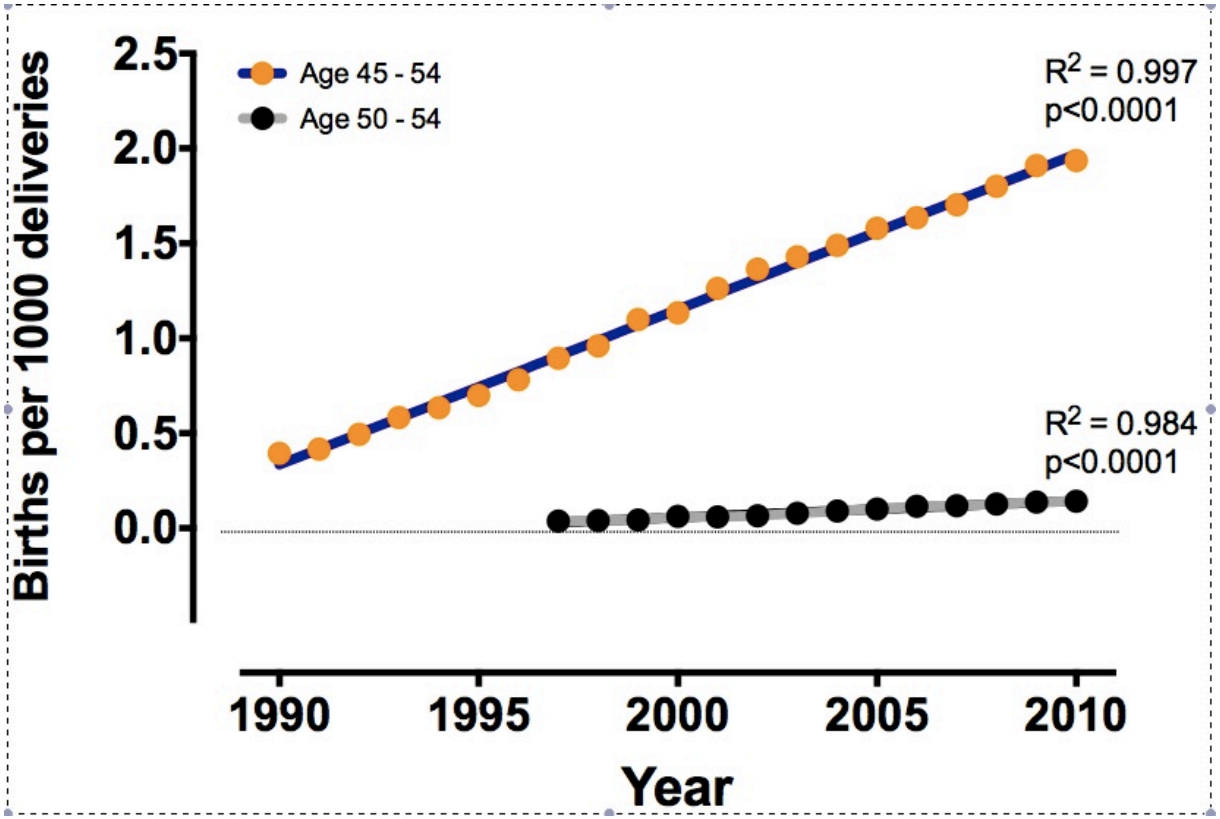
- Progrès des techniques de PMA

Pregnancy complications in women aged 50 years (and 45 years) and older

Chad Grotegut MD[1], Christian Chisholm MD[2], Haywood Brown MD[1], R Phillips Heine MD[1], Andra James MD[2]

[1]Division of Maternal Fetal Medicine, Duke University, Durham, NC, [2]Division of Maternal-Fetal Medicine, University of Virginia, Charlottesville, VA

- Base de données nationale +7M d'accouchements pour 2008-2009, 23000 femmes de plus de 45 ans (dont 880 de 50 ans et +)



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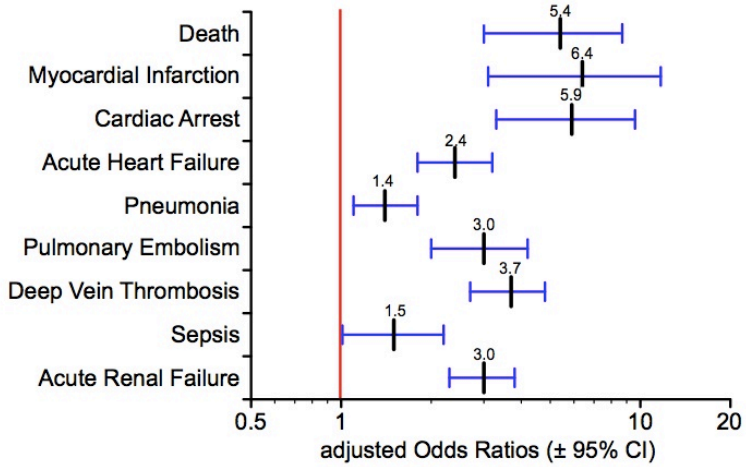
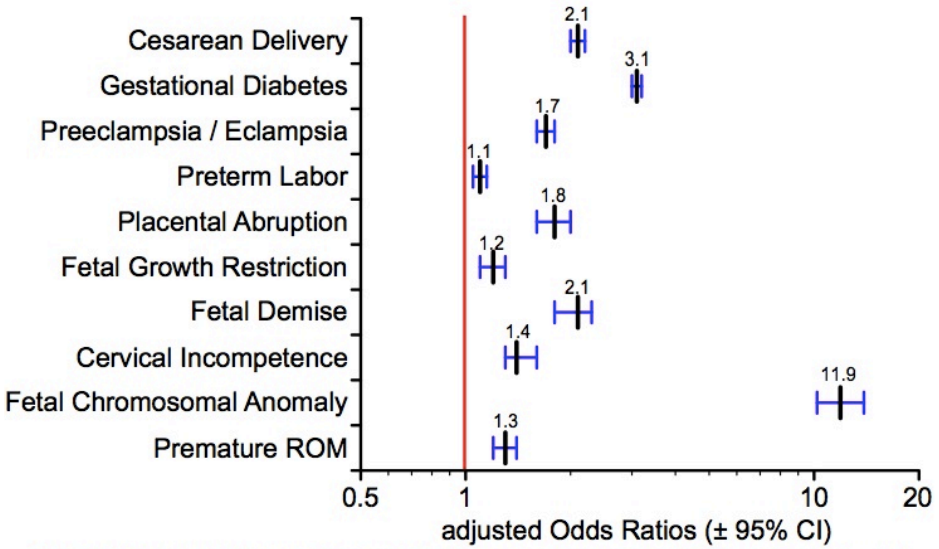
Adjusted Odds Ratios For Various Medical Outcomes In Women 45-Years-Old And Older Compared To Women 35-Years-Old And Younger



Adjusted model for obstetric outcomes among women 45 and older compared to women 35 and younger controlling for multiple gestation, chronic hypertension, chronic renal failure, heart disease, pulmonary disease, endocrine disorders, autoimmune disorders, hematologic disorders, and drug/alcohol abuse.

djusted Odds Ratios For Various Pregnancy Outcomes In Women 45-Years-Old And Older Compared To Women 35-Years-Old And Younger



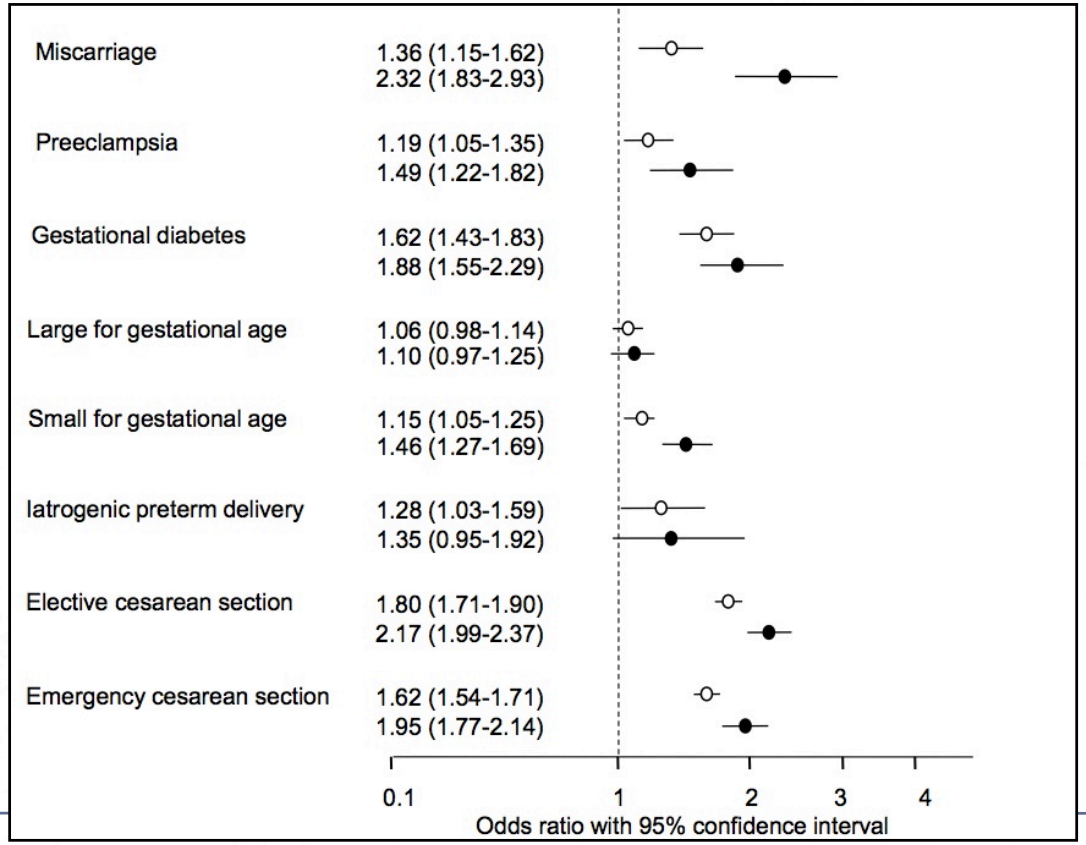
Adjusted model for obstetric outcomes among women 45 and older compared to women 35 and younger controlling for multiple gestation, chronic hypertension, chronic renal failure, heart disease, pulmonary disease, endocrine disorders, autoimmune disorders, hematologic disorders, and drug/alcohol abuse.

Maternal age and adverse pregnancy outcomes: a cohort study

Asma Khalil[1], Argyro Syngelaki[1,2], Nerea Maiz[3], Yana Zinevich[1,2], Kypros H Nicolaides[1,2]

1. Department of Fetal Medicine, Institute for Women's Health, University College London Hospitals, London, UK.
2. Department of Fetal Medicine, King's College Hospital, London, UK.
3. Fetal Medicine Unit. Obstetrics and Gynecology Service. BioCruces Health Research Institute. Hospital Universitario Cruces. University of the Basque Country (UPV/EHU). Barakaldo,Spain.

Cohorte londonienne 76000 femmes dont 4061 de 40 ans et +, suivie dès le 1er trimestre



○ 35-39 ans

● ≥ 40 ans

Ref : <35 ans

Australian and New Zealand Journal of Obstetrics and Gynaecology 2012; **52**: 235–241 DOI: 10.1111/j.1479-828X.2012.01442.x

Original Article

Pregnancy outcomes for nulliparous women of advanced maternal age in South Australia, 1998–2008

Isobel LUDFORD,[1] Wendy SCHEIL,[2] Graeme TUCKER[3] and Rosalie GRIVELL[4]

[1]*Office of Public Health, Department for Health and Ageing,* [2]*Pregnancy Outcome Unit, Epidemiology Branch, Department for Health and Ageing,* [3]*Health Statistics Unit, Epidemiology Branch, Department for Health and Ageing, Adelaide and* [4]*Discipline of Obstetrics and Gynaecology, Women's and Children's Hospital, University of Adelaide, North Adelaide, South Australia, Australia*

- Plus 40 ans *(ref: 25-29 ans)*, risques plus élevés de :
  - Placenta praevia (RR=3.68 [2.26-5.97]) – 1.5%
  - Diabète gestationnel (RR=2.53 [2.09-3.07]) - 8.3%
  - SGA (RR=1.39 [1.21-1.59]) – 14%
  - Prématurité (RR=1.50 [1.27-1.77]) -10.4%
  - Césarienne élective (RR=4.15 [3.69-4.67]) – 18.5%
  - Césarienne en urgence (RR=1.77 [1.65-1.89]) – 37.2%
  - MFIU (RR=2.14 [1.35-3.38]) – 1.5%

De plus en plus de grossesse obtenue par don d'ovocytes

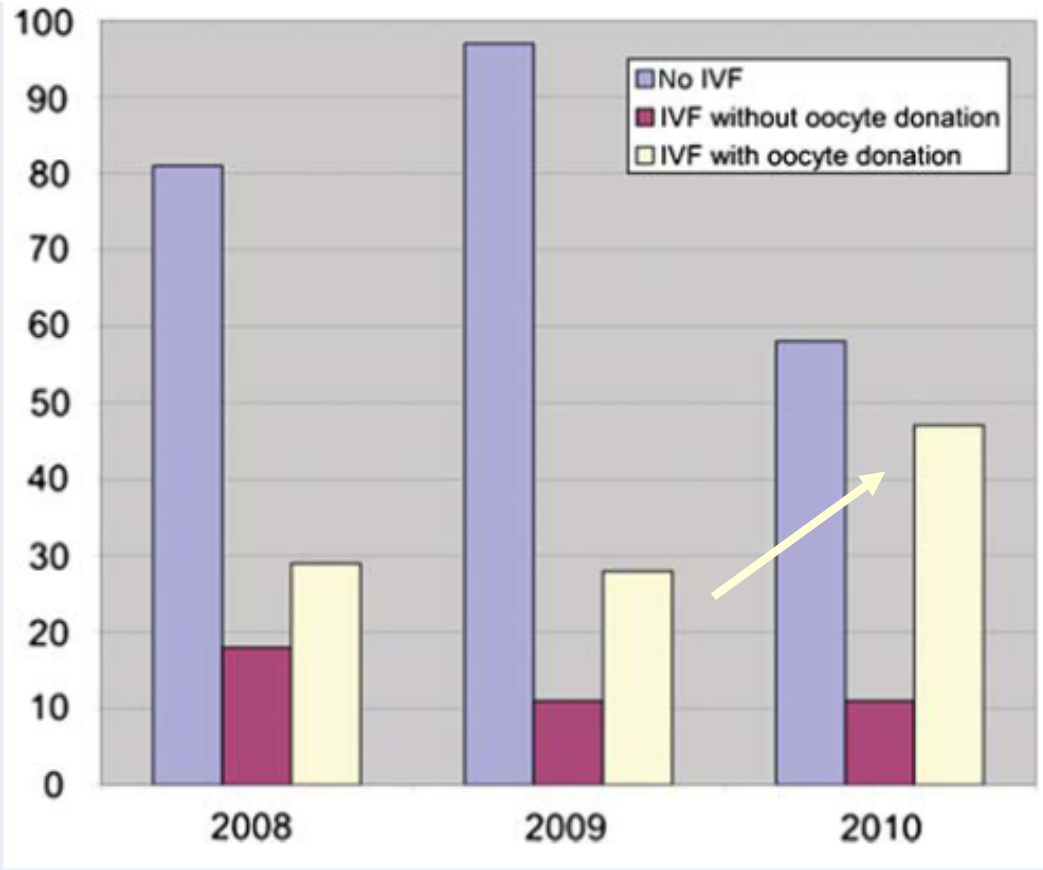
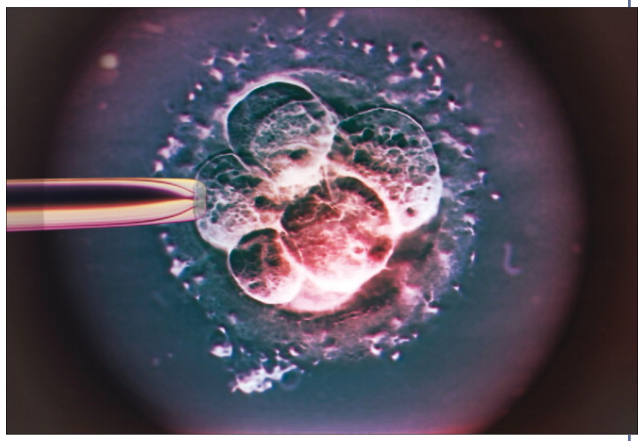


Figure 1 Number of pregnancies according to the mode of conception: Trends in women aged 43 years or older from 1 January 2008 through 31 December 2010.

Origine des dons :
-Espagne
-Grèce
-Belgique
-Tchécoslovaquie
-Albanie



human reproduction

ORIGINAL ARTICLE *Reproductive epidemiology*

Association between oocyte donation and maternal and perinatal outcomes in women aged 43 years or older

C. Le Ray[1,2,*], S. Scherier[1], O. Anselem[1,2], A. Marszalek[2,3], V. Tsatsaris[1,2], D. Cabrol[1,2], and F. Goffinet[1,2]

Janvier 2012

Table II Complications according to mode of conception: univariate analysis.

	No IVF (n = 236)	IVF without oocyte donation (n = 40)	IVF with oocyte donation (n = 104)	P
Pre-eclampsia	9 (3.8)	4 (10.0)	20 (19.2)	<0.001[a]
Gestational diabetes	12 (5.1)	3 (7.5)	8 (7.7)	0.494[a]
Cesarean[c]	86 (37.9)	16 (42.1)	62 (61.4)	0.001[b]
PPH				0.008[a]
Preterm deliv				0.006[b]
Preterm deliv				0.152[a]
Birthweight <				0.340[a]
Birthweight <2500 g[c]	40 (17.2)	14 (31.8)	54 (38.0)	<0.001[b]
IUFD[d]	5 (2.1)	1 (2.5)	1 (1.0)	0.728[a]

Le don est un facteur de risque important de prééclampsie

OR ajusté = 3.3 [1.2-8.9]

Hémorragie du post-partum

Epidemiological investigation of a temporal increase in atonic postpartum haemorrhage: a population-based retrospective cohort study

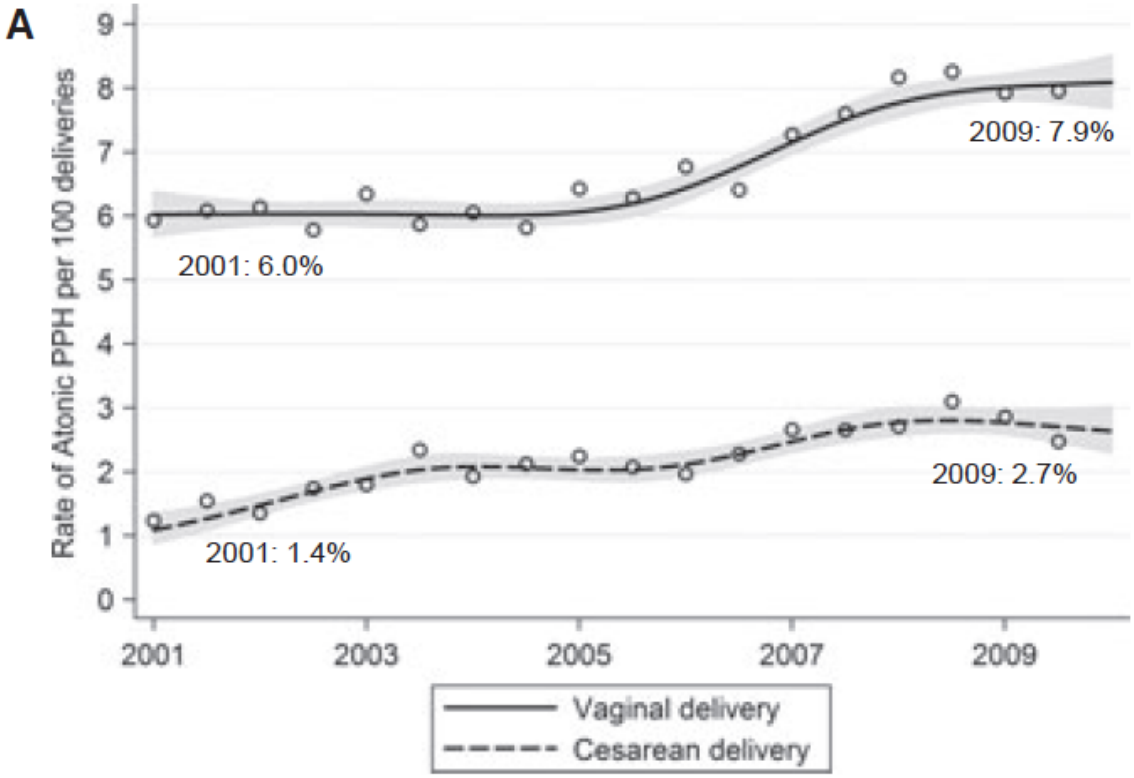
A Mehrabadi,[a,b] JA Hutcheon,[a,b,c] L Lee,[c] MS Kramer,[d] RM Liston,[b] KS Joseph[a,b,c]

[a] Department of Obstetrics and Gynaecology, University of British Columbia and the Children's and Women's Health Centre of British Columbia, Vancouver, BC, Canada [b] School of Population and Public Health, University of British Columbia, Vancouver, BC, Canada [c] Perinatal Services BC, Vancouver, BC, Canada [d] Departments of Pediatrics, Epidemiology, Biostatistics and Occupational Health, McGill University, Montreal, QC, Canada

Correspondence: A Mehrabadi, Room E418B, Shaughnessy Building, 4500 Oak Street, Vancouver, BC, Canada V6H 3N1.
Email azar@interchange.ubc.ca

BJOG 2013

300 000 accouchements, 2001-2009, en Colombie Britannique

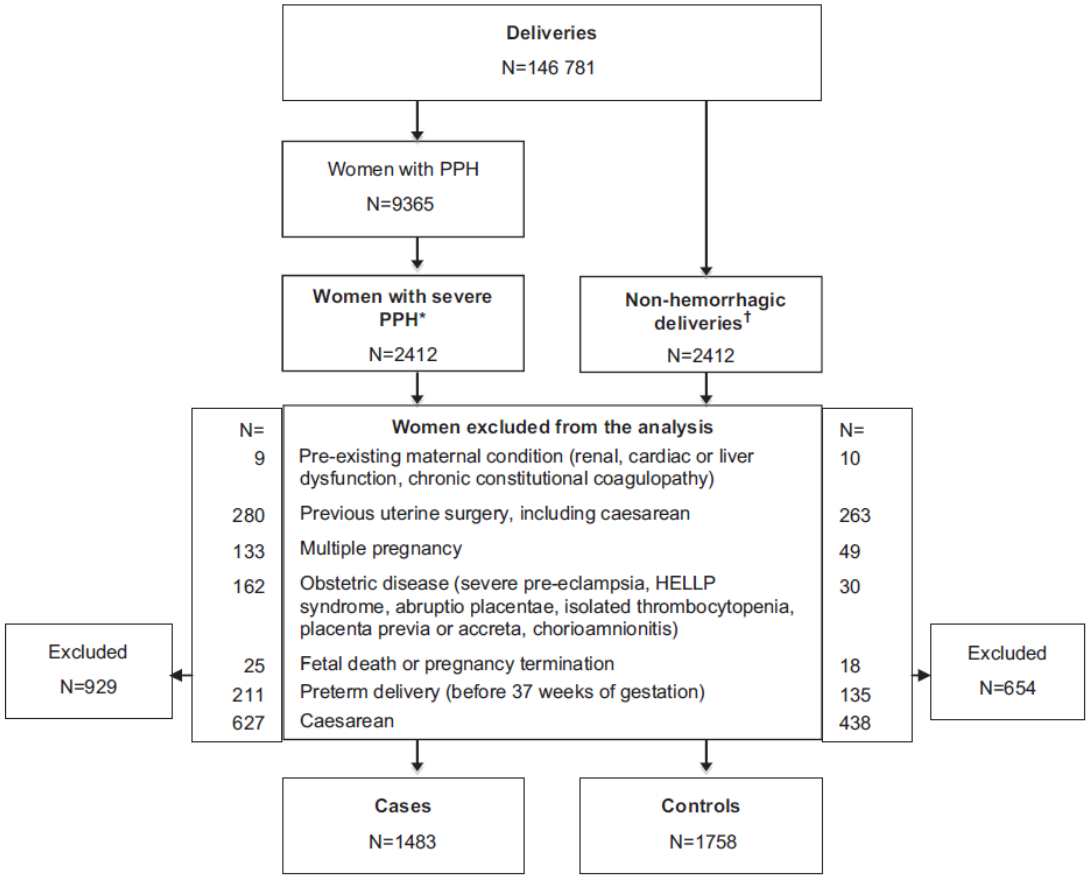


Rôle de l'ocytocine pendant le travail ?

Oxytocin during labour and risk of severe postpartum haemorrhage: a population-based, cohort-nested case–control study

BMJ open
accessible medical research

Jérémie Belghiti,[1] Gilles Kayem,[1] Corinne Dupont,[2] René-Charles Rudigoz,[2] Marie-Hélène Bouvier-Colle,[1] Catherine Deneux-Tharaux[1]



- Essai PITHAGORE6
- Données françaises en population
- 6 réseaux – 106 maternités (20% des accouchements)
- 2005-2006

	Women with severe PPH (N=1483), n (%)*	Controls (N=1758), n (%)*	Crude OR (95% CI)
Oxytocin during labour	1088 (73)	1077 (61)	1.7 (1.5 to 2.0)
Oxytocin total dose (IU)†			
Mean (SD)	2.4 (2.5)	1.6 (3.0)	
Median (25th, 75th pc)	1.6 (0.6, 3.4)	0.9 (0.3, 2.0)	
No oxytocin	395 (27)	681 (42)	Ref
<1.0	377 (26)	511 (31)	1.3 (1.1 to 1.5)
1.0–<2.0	229 (16)	207 (13)	1.9 (1.5 to 2.4)
2.0–<4.0	244 (17)	157 (10)	2.7 (2.1 to 3.4)
≥4.0	217 (15)	83 (5)	4.5 (3.4 to 6.0)
MD	21 (1)‡	119 (7)‡	
Maximal infusion rate (mIU/min)†			
Mean (SD)	9.8 (6.0)	8.2 (5.3)	
Median (25th, 75th pc)	8.3 (5, 12.5)	7.5 (5, 10)	
No oxytocin	395 (27)	681 (42)	Ref
<7.5	354 (24)	413 (25)	1.5 (1.2 to 1.8)
7.5–<10	184 (13)	187 (12)	1.7 (1.3 to 2.2)
10–<15	293 (20)	213 (13)	2.4 (1.9 to 2.9)
≥15	237 (16)	128 (8)	3.2 (2.5 to 4.1)
MD	20 (1)‡	136 (8)‡	
Total time of oxytocin infusion (min)†			
Mean (SD)	295 (187)	217 (158)	
Median (25th, 75th pc)	266 (150, 408)	182 (98, 294)	
No oxytocin	395 (27)	681 (39)	Ref
<180	342 (23)	517 (30)	1.1 (0.9 to 1.4)
180–<300	275 (19)	279 (16)	1.7 (1.4 to 2.1)
300–<420	215 (15)	158 (9)	2.3 (1.8 to 3.0)
≥420	255 (17)	100 (6)	4.4 (3.4 to 5.7)
MD	1 (0.1)‡	23 (1)‡	
Time at maximal infusion rate (min)†			
Mean (SD)	128 (109)	103 (91)	
Median (25th, 75th pc)	100 (45, 180)	78 (40, 140)	
No oxytocin	395 (28)	681 (44)	Ref
<90	471 (33)	472 (31)	1.7 (1.4 to 2.1)
90–150	216 (15)	198 (13)	1.9 (1.5 to 2.4)
150–210	136 (10)	109 (7)	2.2 (1.6 to 2.8)
≥210	201 (14)	87 (6)	4.0 (3.0 to 5.3)
MD	64 (4)‡	211 (12)‡	

Oxytocin during labour and risk of severe postpartum haemorrhage: a population-based, cohort-nested case–control study

BMJ open accessible medical research 2012

Jérémie Belghiti,[1] Gilles Kayem,[1] Corinne Dupont,[2] René-Charles Rudigoz,[2] Marie-Hélène Bouvier-Colle,[1] Catherine Deneux-Tharaux[1]

- Femmes sans délivrance dirigée, augmentation significative du risque d'HPP pour :
  - Ocytocine (ORa=1.8 [1.3-2.6])
  - Risque croissant avec la dose (ORa de 2.0 à 5.7)
  - Risque croissant avec le débit max (ORa de 1.9 à 3.2)
  - Risque croissant avec le temps d'exposition (ORa de 1.7 à 5.1)
- Femmes avec délivrance dirigée, augmentation non significative pour l'ocytocine seule, mais :
  - Risque croissant d'HPP sévère avec la dose (Ora de 1.5 à 2.1)
  - Dès de faible dose = risque augmenté dès 1 UI d'ocytocine au total

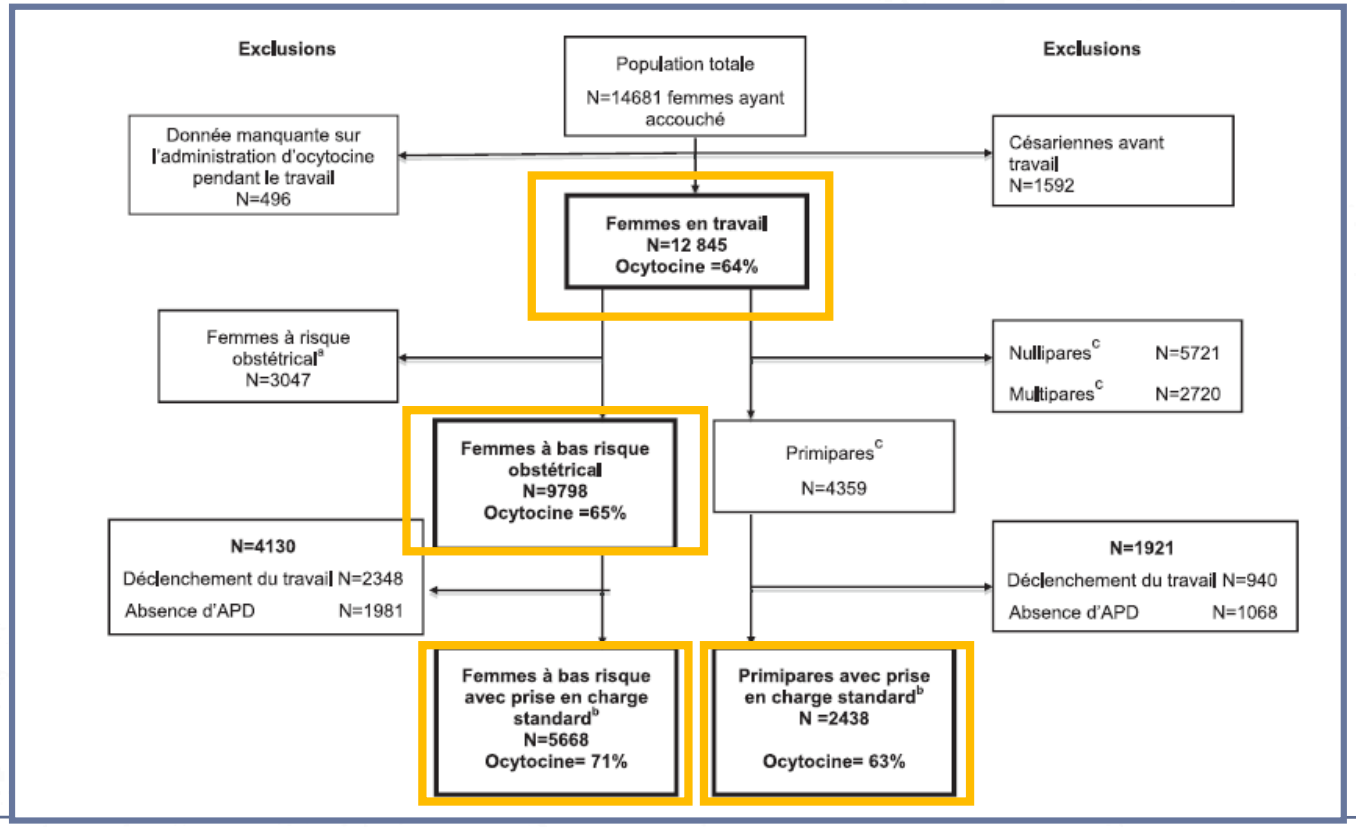
Administration d'ocytocine au cours du travail en France. Résultats de l'enquête nationale périnatale 2010

2013

Oxytocin administration during labor. Results from the 2010 French National Perinatal Survey

J. Belghiti[a,b], B. Coulm[a,b], G. Kayem[a,c], B. Blondel[a,b], C. Deneux-Tharaux[a,*,b]

[a] *Inserm UMR S953, unité de recherche épidémiologique en santé périnatale et santé des femmes et des enfants, maternité Port-Royal, 53, avenue de l'Observatoire, 75014 Paris, France*
[b] *Université Pierre-et-Marie-Curie Paris 6, 75005 Paris, France*
[c] *Université Denis Diderot Paris 7, 75013 Paris, France*

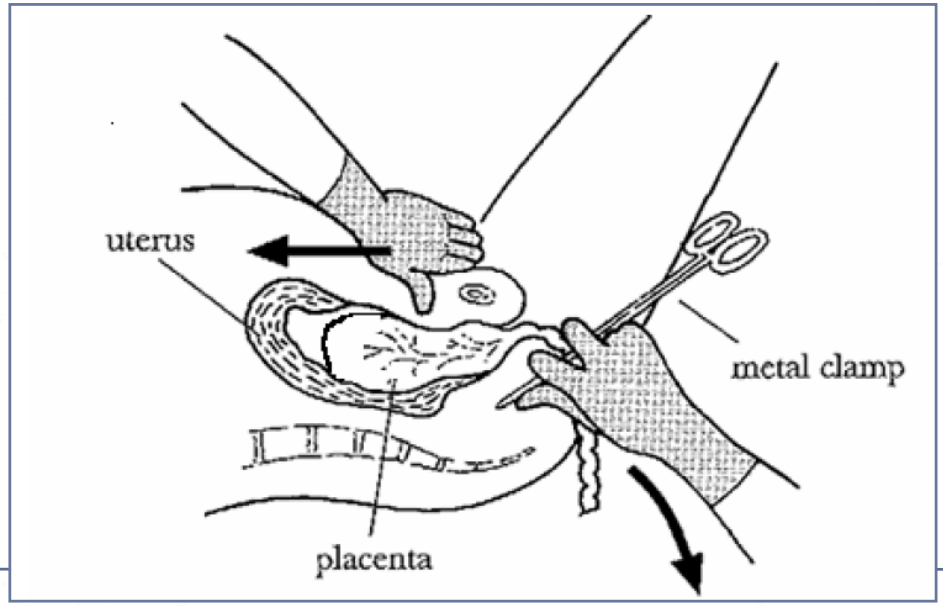


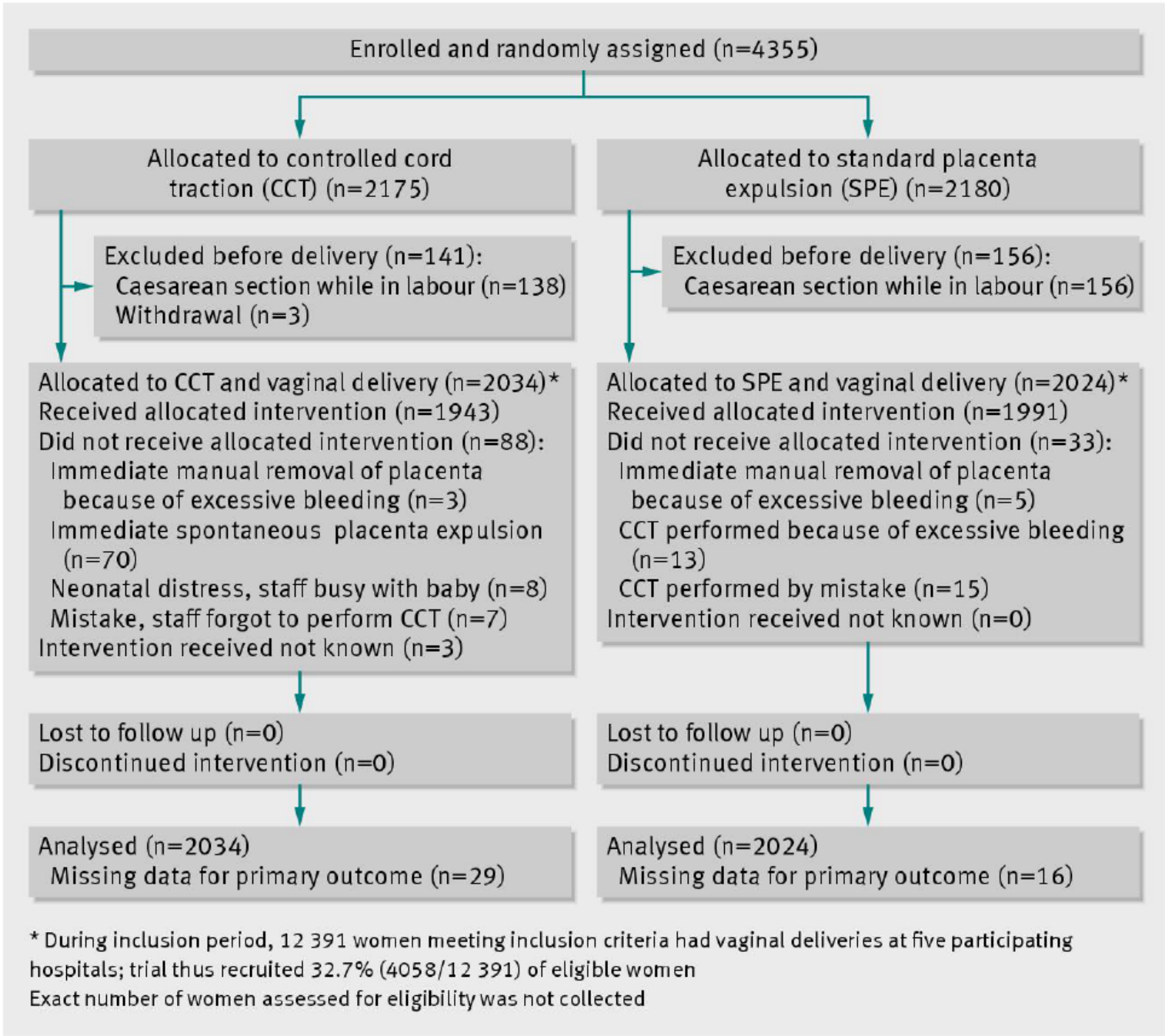
Effect of routine controlled cord traction as part of the active management of the third stage of labour on postpartum haemorrhage: multicentre randomised controlled trial (TRACOR)

BMJ 2013

Catherine Deneux-Tharaux *senior researcher*[1], Loic Sentilhes *professor of obstetrics and gynaecology*[2], Françoise Maillard *medical statistician*[1], Emmanuel Closset *hospital practitioner in obstetrics and gynaecology*[3], Delphine Vardon *hospital practitioner in obstetrics and gynaecology*[4], Jacques Lepercq *professor of obstetrics and gynaecology*[5], François Goffinet *professor of obstetrics and gynaecology and senior researcher*[1 6]

[1]INSERM U953, Epidemiologic Research in Perinatal, Women's, and Children's Health, Pierre et Marie Curie University, Paris, France; [2]Department of Obstetrics and Gynaecology, University Hospital, Angers, France; [3]Department of Obstetrics and Gynaecology, Jeanne de Flandre University Hospital, Lille, France; [4]Department of Obstetrics and Gynaecology, University Hospital, Caen, France; [5]Department of Obstetrics and Gynaecology, St Vincent de Paul-Cochin University Hospital, Assistance Publique Hôpitaux de Paris, Paris; [6]Port-Royal Maternity Unit, Department of Obstetrics and Gynaecology, Cochin University Hospital, Assistance Publique Hôpitaux de Paris, Paris



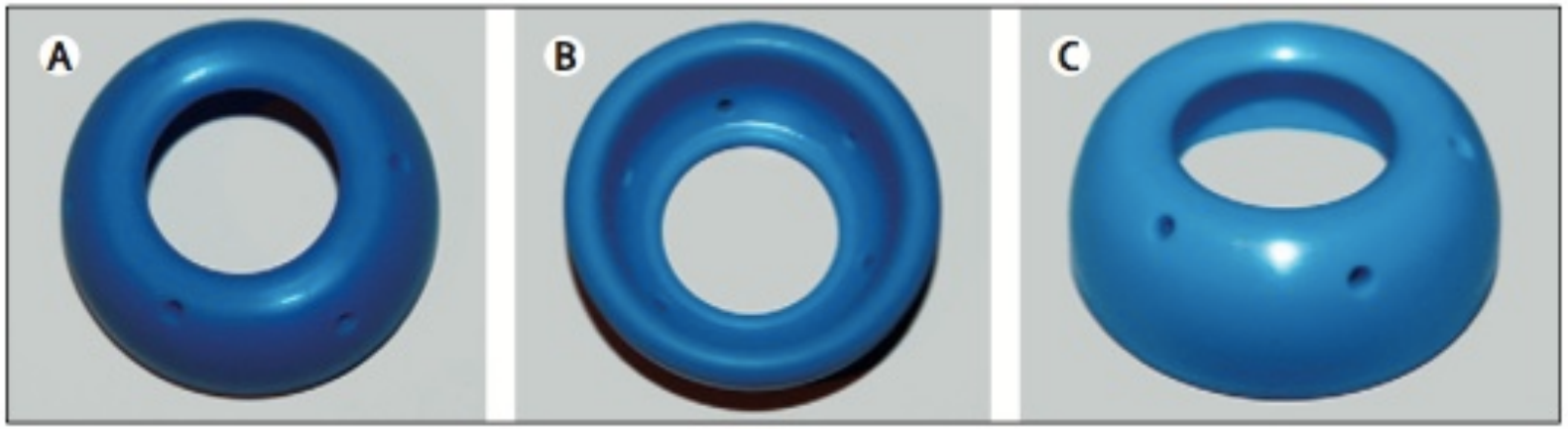

Enrolled and randomly assigned (n=4355)
Allocated to controlled cord traction (CCT) (n=2175)
Allocated to standard placenta expulsion (SPE) (n=2180)
Excluded before delivery (n=141):
Caesarean section while in labour (n=138)
Withdrawal (n=3)
Excluded before delivery (n=156):
Caesarean section while in labour (n=156)
Allocated to CCT and vaginal delivery (n=2034)*
Received allocated intervention (n=1943)
Did not receive allocated intervention (n=88):
Immediate manual removal of placenta because of excessive bleeding (n=3)
Immediate spontaneous placenta expulsion (n=70)
Neonatal distress, staff busy with baby (n=8)
Mistake, staff forgot to perform CCT (n=7)
Intervention received not known (n=3)
Allocated to SPE and vaginal delivery (n=2024)*
Received allocated intervention (n=1991)
Did not receive allocated intervention (n=33):
Immediate manual removal of placenta because of excessive bleeding (n=5)
CCT performed because of excessive bleeding (n=13)
CCT performed by mistake (n=15)
Intervention received not known (n=0)
Lost to follow up (n=0)
Discontinued intervention (n=0)
Lost to follow up (n=0)
Discontinued intervention (n=0)
Analysed (n=2034)
Missing data for primary outcome (n=29)
Analysed (n=2024)
Missing data for primary outcome (n=16)
* During inclusion period, 12 391 women meeting inclusion criteria had vaginal deliveries at five participating hospitals; trial thus recruited 32.7% (4058/12 391) of eligible women
Exact number of women assessed for eligibility was not collected

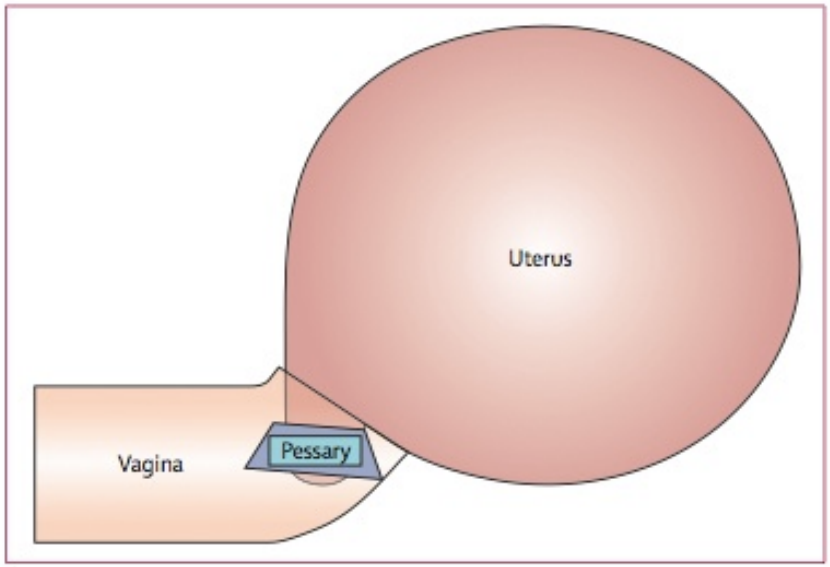
Outcomes	Controlled cord traction	Standard placenta expulsion	Relative risk (95% CI)	Mean difference (95% CI)
Blood loss ≥500 mL	196/2005 (9.8)	206/2008 (10.3)	0.95 (0.79 to 1.15)	—
By hospital:			0.31*	
Port-Royal maternity hospital	46/473 (9.7)	37/482 (7.7)	1.27 (0.84 to 1.92)	—
Saint Vincent de Paul University hospital	20/199 (10.1)	14/196 (7.1)	1.41 (0.73 to 2.71)	—
Caen U				
Lille Un				
Angers				
Blood los				
Mean (S (mL)				
Mean (S				
Blood transfusion for postpartum haemorrhage	12/2034 (0.6)	9/2024 (0.4)	1.33 (0.56 to 3.14)	—
Arterial embolisation or surgery for postpartum haemorrhage	3/2034 (0.1)	5/2024 (0.3)	0.60 (0.14 to 2.49)	—
Mean (SD) peripartum change in haemoglobin (g/L)†	86 (0.3) (n=1961)	87 (0.3) (n=1953)	—	−0.2 (−1.0 to 0.7)
Mean (SD) peripartum change in haematocrit (%)‡	2.1 (0.1) (n=1904)	2.2 (0.1) (n=1890)	—	−0.05 (−0.29 to 0.19)
Mean (SD) duration of third stage (min)	5.5 (0.1) (n=2030)	8.7 (0.1) (n=2020)	—	−3.26 (−3.62 to −2.90)
Third stage ≥15 minutes	91/2030 (4.5)	289/2020 (14.3)	0.31 (0.25 to 0.39)	—
Manual removal of placenta	85/2033 (4.2)	123/2024 (6.1)	0.69 (0.53 to 0.90)	—
Additional uterotonics after placenta delivery	727/2030 (35.8)	805/2024 (39.8)	0.92 (0.83 to 0.97)	—
Maternal pain during third stage	109/1892 (5.8)	138/1868 (7.4)	0.78 (0.61 to 0.99)	—
Cord rupture	89/2034 (4.4)	2/2024 (0.1)	44.3 (10.9 to 179.6)	—
Uterine inversion	0/2034 (0.0)	0/2024 (0.0)	—	—

Aucune différence entre TCC et expulsion standard concernant le risque d'HPP

Outcomes	Controlled cord traction	Standard placenta expulsion	Relative risk (95% CI)	Mean difference (95% CI)
Blood loss ≥500 mL	196/2005 (9.8)	206/2008 (10.3)	0.95 (0.79 to 1.15)	—
By hospital:			0.31*	
Port-Royal maternity hospital	46/473 (9.7)	37/482 (7.7)	1.27 (0.84 to 1.92)	—
Saint Vincent de Paul University hospital	20/199 (10.1)	14/196 (7.1)	1.41 (0.73 to 2.71)	—
Caen University hospital	40/344 (11.6)	49/330 (14.9)	0.78 (0.53 to 1.16)	—
Lille University hospital	38/445 (8.5)	42/443 (9.5)	0.90 (0.59 to 1.37)	—
Angers University hospital	52/544 (9.6)	64/557 (11.5)	0.83 (0.59 to 1.18)	—
Blood loss ≥1000 mL	34/2005 (1.7)	37/2008 (1.8)	0.92 (0.58 to 1.46)	—
Mean (SD) blood loss at 15 minutes (mL)	163 (4) (n=2005)	161 (4) (n=2001)	—	1.7 (−8.8 to 12.2)
Mean (SD) total blood loss (mL)	207 (5) (n=2005)	217 (6) (n=2008)	—	−9.4 (−24.8 to 6.0)
Blood transfusion for postpartum haemorrhage	12/2034 (0.6)	9/2024 (0.4)	1.33 (0.56 to 3.14)	—
Arterial embolisation or surgery for postpartum haemorrhage	3/2034 (0.1)	5/2024 (0.3)	0.60 (0.14 to 2.49)	—
Mean (SD) peripartum change in haemoglobin (g/L)†	86 (0.3) (n=1961)	87 (0.3) (n=1953)	—	−0.2 (−1.0 to 0.7)
Mean (SD) peripartum change in haematocrit (%)‡	2.1 (0.1) (n=1904)	2.2 (0.1) (n=1890)	—	−0.05 (−0.29 to 0.19)
Mean (SD) duration of third stage (min)	5.5 (0.1) (n=2030)	8.7 (0.1) (n=2020)	—	−3.26 (−3.62 to −2.90)
Third stage ≥15 minutes	91/2030 (4.5)	289/2020 (14.3)	0.31 (0.25 to 0.39)	—
Manual removal of placenta	85/2033 (4.2)	123/2024 (6.1)	0.69 (0.53 to 0.90)	—
Additional uterotonics after placenta delivery	727/2030 (35.8)	805/2024 (39.8)	0.92 (0.83 to 0.97)	—
Maternal pain during third stage	109/1892 (5.8)	138/1868 (7.4)	0.78 (0.61 to 0.99)	—
Cord rupture	89/2034 (4.4)	2/2024 (0.1)	44.3 (10.9 to 179.6)	—
Uterine inversion	0/2034 (0.0)	0/2024 (0.0)	—	—

Le Pessaire pour diminuer la prématurité, l'avenir ?

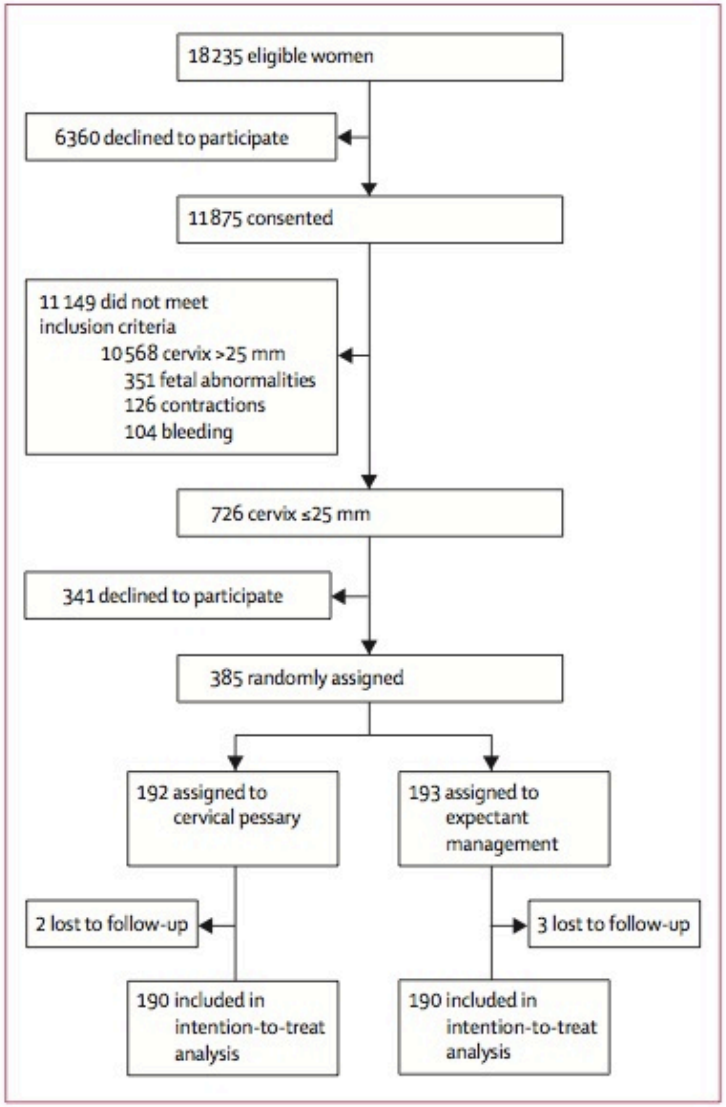




Cervical pessary in pregnant women with a short cervix (PECEP): an open-label randomised controlled trial

Lancet 2012

Maria Goya, Laia Pratcorona, Carme Merced, Carlota Rodó, Leonor Valle, Azahar Romero, Miquel Juan, Alberto Rodríguez, Begoña Muñoz, Belén Santacruz, Juan Carlos Bello-Muñoz, Elisa Llurba, Teresa Higueras, Luis Cabero, Elena Carreras*, on behalf of the Pesario Cervical para Evitar Prematuridad (PECEP) Trial Group*



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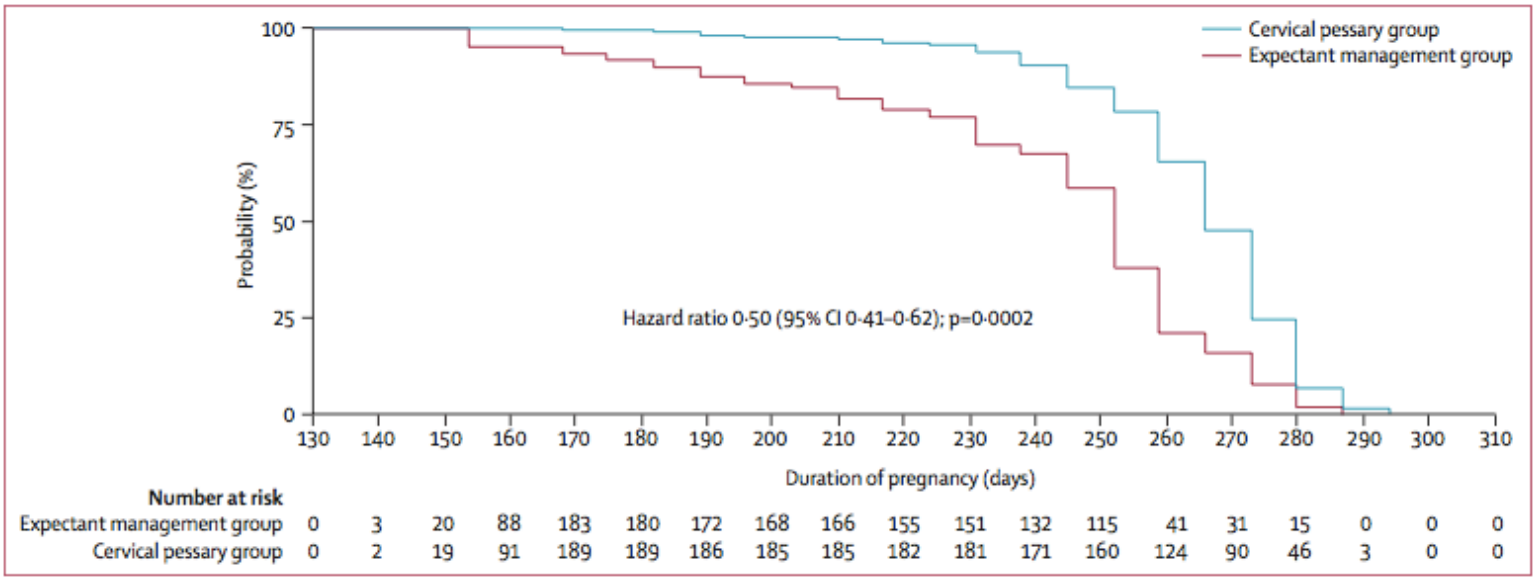


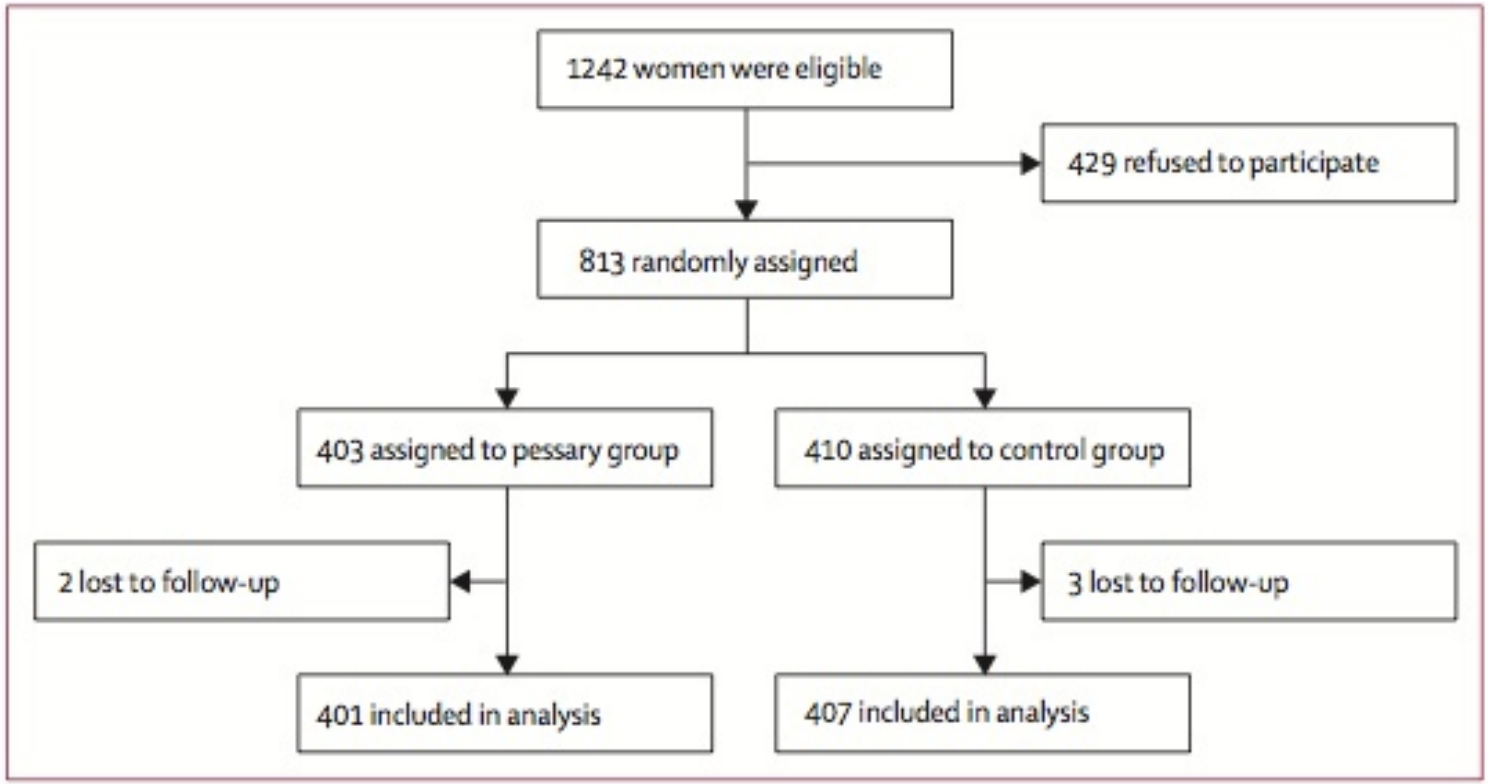
	Cervical pessary group (n=190)	Expectant management group (n=190)	Odds ratio (95% CI)	p value
Pregnancy outcome				
Spontaneous delivery before 28 weeks	4 (2%)	16 (8%)	0·23 (0·06–0·74)	0·0058
Spontaneous delivery before 34 weeks	12 (6%)	51 (27%)	0·18 (0·08–0·37)	<0·0001
Any delivery before 34 weeks	14 (7%)	53 (28%)	0·21 (0·10–0·40)	<0·0001
Spontaneous delivery before 37 weeks	41 (22%)	113 (59%)	0·19 (0·12–0·30)	<0·0001
Gestational age at delivery (weeks)	37·7 (2·0)	34·9(4·0)	..*	<0·0001

Cervical pessaries for prevention of preterm birth in women with a multiple pregnancy (ProTWIN): a multicentre, open-label randomised controlled trial

Lancet 2013

Sophie Liem, Ewoud Schuit, Maud Hegeman, Joke Bais, Karin de Boer, Kitty Bloemenkamp, Jozien Brons, Hans Duvekot, Bas Nij Bijvank, Maureen Franssen, Ingrid Gaugler, Irene de Graaf, Martijn Oudijk, Dimitri Papatsonis, Paula Pernet, Martina Porath, Liesbeth Scheepers, Marko Sikkema, Jan Sporken, Harry Visser, Wim van Wijngaarden, Mallory Woiski, Mariëlle van Pampus, Ben Willem Mol, Dick Bekedam

Femmes éligibles : toutes les grossesses gémellaires



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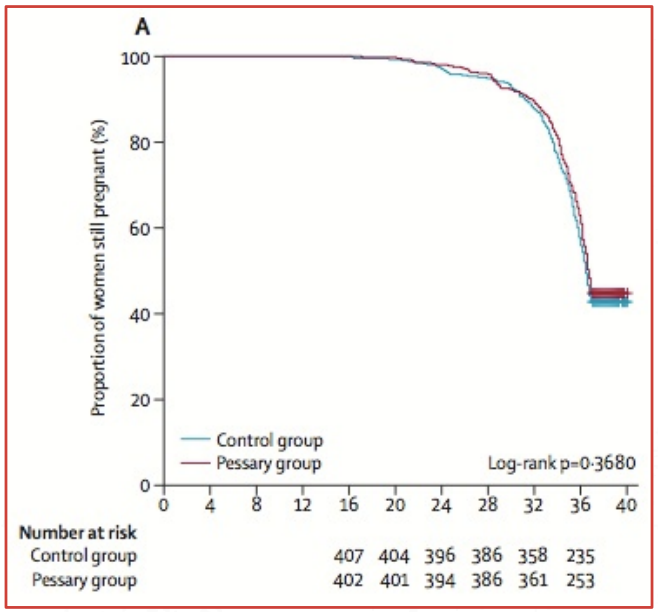
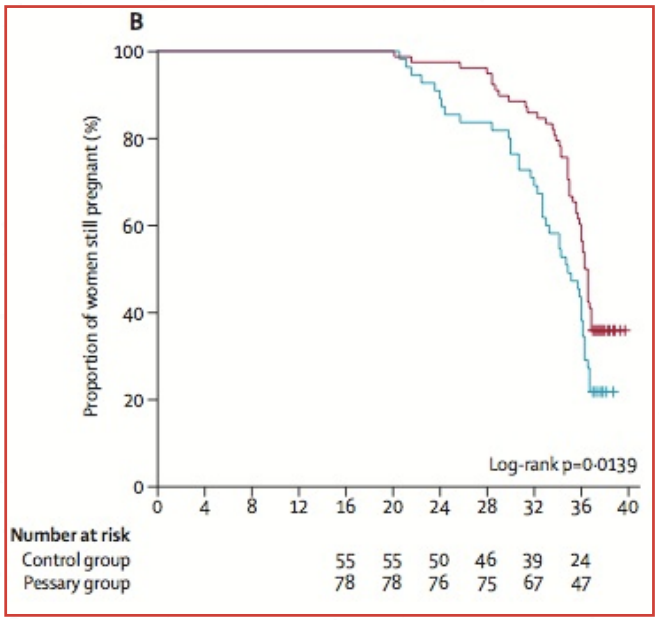
Pas de différence pour le risque de prématurité et les outcomes néonataux dans l'ensemble de la population





Mais différence dans le sous-groupe des femmes ayant un col raccourci (<38mm)

ClinicalTrials.gov

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6 essais en cours évaluant l'intérêt du pessaire pour diminuer le risque de prématurité

Quoi de neuf en Obstétrique en 2014 ?