CRDB Catheter Falls Short in Some Cases

BY PATRICE WENDLING

CHICAGO — The cervical-ripening double-balloon catheter has a more favorable effect on cervical ripening than a Foley catheter in nulliparous, but not multiparous, women, according to a prospective randomized trial in 200 women.

**Major Finding:** The mean interval from catheter withdrawal to delivery time was 9 hours for the CRDB catheter vs. 14 hours for the Foley catheter in multiparous women in the first study, a nonsignificant difference. Time from insertion to delivery was significantly less at a mean of 19 hours with the Foley vs. a mean of 23 hours with the CRDB in the second study.

**Data Source:** Two prospective, randomized studies comparing the CRDB catheter with the Foley catheter, the first in 200 women and the second in 188 women.

**Disclosures:** None was reported.

Israeli investigators compared the two devices after noting that labor induction rates had risen to 27% of pregnancies in their hospital and that the cervical ripening double-balloon catheter (Cook Medical) costs about 10 times more than a Foley catheter. A single CRDB catheter (Cook Medical) costs about $3.50 for a Foley set and at $41 for the CRDB.

In nulliparous women, the increment in the Bishop score from catheter insertion until withdrawal or expulsion was significantly higher at a mean of 4.4 in the CRDB group, compared with a mean of 3.4 in the Foley group. Dr. Ido Solt and associates reported in a poster at the annual meeting of the Society for Maternal-Fetal Medicine.

The mean interval from catheter withdrawal to delivery time was significantly shorter at 15 hours in the CRDB group vs. 23 hours in the Foley group. None of 45 (20%) nulliparous women in the CRDB group had a cesarean section, compared with 20 of 50 (40%) nulliparous women in the Foley group, which was statistically significant.

No significant differences were observed in multiparous women between the two catheters, reported Dr. Solt of the department of obstetrics and gynecology at Western Galilee Hospital in Nahariya, Israel.

The mean interval from catheter withdrawal to delivery time was 9 hours for the CRDB catheter vs. 14 hours for the Foley catheter.

Cesarean sections occurred in 17% of the 41 multiparous women who received a CRDB, vs. 16% of 44 nulliparous women receiving a Foley. A second poster presented at the same meeting reported that the Foley catheter with extra-amniotic saline infusion was a faster cervical-ripening device than the CRDB in a randomized trial involving 93 nulliparous and 95 multiparous women.

The primary outcome of time from insertion to delivery was significantly less at a mean of 19 hours with the Foley catheter vs. a mean of 23 hours with the CRDB, reported Dr. Elad MeI-Dan of Hillel Yaffe Medical Center in Hadera, Israel, and associates. Mean insertion to expulsion time was also significantly shorter at 7 hours with the Foley vs. 10 hours with the CRDB.

Ripening success was similar at 97% with the Foley and 99% with the CRDB. Cesarean section rates were also similar at 21% and 20%.

Patient satisfaction on a 10-point scale was 7 with the Foley catheter and 6.6 with the CRDB catheter, which was not statistically different. In light of the findings and the significant cost difference between the two devices, a Foley catheter should be preferred initially, Dr. MeI-Dan said in an interview. He put the price at $3.30 for a Foley set and $41 for the CRDB.

He noted that he and his associates still use the CRDB when a Foley catheter fails to achieve cervical ripening or when the preinduction cervical dilation is too big to hold the Foley balloon, but can still hold the Cook balloons.

CRDB catheter withdrawal to delivery time was 9 hours for the CRDB catheter vs. 14 hours for the Foley catheter.

**Disclosures:** None was reported.

No Raised Risk With Multiple Steroid Courses

BY PATRICE WENDLING

CHICAGO — The risk of death or neurologic impairment was similar at 2 years after exposure to either single or multiple courses of antenatal corticosteroids, according to a follow-up analysis of data from the multicenter MACS trial.

“Continued follow-up of these children is important and necessary to determine if there are subtle effects of steroid exposure that only become evident in later years,” Dr. Elizabeth Asztalos said at the annual meeting of the Society of Maternal-Fetal Medicine.

The findings are encouraging as the same group previously reported that multiple courses of antenatal corticosteroids (ACS) given at 14-day intervals do not improve perinatal birth outcomes and are associated with a significant decrease in weight, length, and head circumference at birth (Lancet 2008;372:2143-51).

“Therefore, this treatment schedule is not recommended,” the authors wrote.

MACS, the Multiple Courses of Antenatal Corticosteroids for Preterm Birth Study, included women who were at high risk of perinatal birth at 25-32 weeks’ gestation. All of the women received an initial course of ACS. There were 1,858 women who were undelivered and remained at high risk at 14-21 days after the initial course of ACS. These women were randomized to either ACS or placebo given every 14 days until week 33 or delivery, whichever came first.

The secondary composite outcome of death or neurologic impairment was evaluated at 18-24 months. Neurologic impairment was defined as cerebral palsy or abnormal cognitive development defined by a Mental Development Index (MDI) score of less than 70 on the Bayley Scales of Infant Development–Second Edition.

Evaluations were conducted in 1,069 infants exposed to multiple courses of ACS and 1,035 infants exposed to placebo at a median of 22 months old.

The occurrence rate of the composite outcome was nearly identical—13.8% (148) of the ACS group and in 13.7% (142) of the placebo group, said Dr. Asztalos of the department of Newborn & Developmental Paediatrics, Sunnybrook Research Institute in Toronto. Also, the components of the composite outcome were nearly identical—mortality (49 vs. 47), cerebral palsy (24 vs. 25), and cognitive impairment (86 vs. 84).

**Disclosures:** None was reported.

Neonatal MRSA Often Community Acquired

BY KATE JOHNSON

MONTREAL — Community-acquired strains are the most common source of methicillin-resistant *Staphylococcus aureus* colonization and infection in babies in the neonatal intensive care unit, even though they have never left the hospital, researchers have found.

Findings in a 5-year retrospective study of 50 MRSA-colonized neonates in the NICU were presented at the annual meeting of the Infectious Diseases Society for Obstetrics and Gynecology.

“There are higher rates of community-acquired MRSA infection in our neonates than in our general adult and pediatric patient population,” lead investigator Dr. Gweneth Mei-Dan of Hillel Yaffe Medical Center in Hadera, Israel, and associates. Continued follow-up of these children is important and necessary to determine if there are subtle effects of steroid exposure that only become evident in later years,” Dr. Elizabeth Asztalos said at the annual meeting of the Society of Maternal-Fetal Medicine.

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