“Effectiveness of Timing Strategies for Delivery of Individuals With Placenta Previa and Accreta”  
(Barrett K. Robinson, MD, MPH, and William A. Grobman, MD, MBA)  
Click Here to Read the Full Article

1. Describe the study design. What is a decision tree and why did the authors use this method? What are the strengths and limitations of this study design?

2. How are outcomes selected to be included? Discuss the outcomes selected by the authors (maternal intensive care unit admission, perinatal mortality, infant mortality, respiratory distress syndrome, mental retardation, and cerebral palsy). Are these the typical morbidities for deliveries at 34–39 weeks? How might including lesser morbidities (transient tachypnea of the newborn, transition difficulties, neonatal intensive care unit admission, etc) change the outcome? Would it be important to capture these outcomes?

3. Ultimately what is the most important outcome for pregnancy: short term (eg, Apgar scores, birth weight, neonatal intensive care unit admission, morbidity/mortality), intermediate (eg, hospital course), or long term (health at age 2, age 5, or age 10)? Why do studies typically use immediate or short-term outcomes?

4. The authors describe using a sensitivity analysis in their results. What does this mean?

5. What are quality-adjusted life years? Why are they used in this type of analysis? What are they defining?

6. Clinically, some physicians may perform an amniocentesis prior to delivery and, if the lecithin/sphingomyelin ratio is immature, administer corticosteroid followed by delivery in 48 or more hours (delivery within a week). Why didn’t the authors incorporate this scenario in their study? Clinically is this an appropriate use of antenatal corticosteroids? How often are the lungs mature 48+ hours after antenatal corticosteroid administration between 34 and 37 weeks?

7. The authors state that ultrasound can be used to identify placenta accreta in the setting of placenta previa. How accurate is ultrasound in detecting placenta accreta? What is its positive and negative predictive value? Are you comfortable using ultrasound to diagnose accreta?

8. The authors conclude that a scheduled delivery at 34 weeks of gestation is the preferred strategy, without an amniocentesis. In your practice, when you identify placenta previa with ultrasonographic evidence of placenta accreta, what is your current delivery plan?

9. Review the UpToDate document, “Management of placenta previa.” Given the findings in this article, should the management plan be revised?

10. Will the findings from this article alter your practice? What changes, if any, will you make?