ID: 152

TITLE: ACTIVE PERINATAL CARE OF PRETERM INFANTS IN THE GERMAN NEONATAL NETWORK

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CONTENT:

Active perinatal care was reported to improve survival rates of extremely immature infants in nationwide cohort studies and research networks as well as in single centre reports. Between-hospital variation with regard to active care of extremely premature infants is huge. Furthermore, causes and timing of death in premature infants are associated with gestational age. In our network, centres receive yearly written reports comparing their own outcome and treatment data with data from all other centres and a subgroup of centres with extremely low mortality rates. We analysed whether gestational age specific changes in survival occur over time and whether these are influenced by centre specific performance in the past.

We analysed data of VLBWI born between 22 0/7 – 28 6/7 weeks of gestation from 43 tertiary centres participating in the GNN between 1st of January 2011 and 31st of December 2016. Infants not receiving active perinatal care were excluded. Active care was defined as any postnatal intervention (e.g. continuous positive airway pressure, mechanical ventilation). Participating NICUs were categorized according to their death rate in 2011-2013. We used total death rate without adjusting for gestational age or other differences between NICUs. Estimation of overall mortality was calculated. We compared baseline and mortality data for the years 2011-2013 vs. 2014-2016.

Total survival increased from 85.8 % in 2011-2013 to 87.4 % in 2014-2016. This increase was due to reduced mortality of NICUs with low survival rates in 2011-2013. Survival increased in these centres from 53% to 64% in the 22-24 weeks strata and from 73% to 84% in the 25-26 weeks strata. Range of centre specific proportion on all infants who received active care was wide for infants at 22 weeks. Some centres did not execute active care in this age group, but one centre performed active care in 43.3% of all infants in our database at 22 weeks. Infants receiving active care in NICUs with high survival rates in 2011-2013 had a lower gestational age and lower birth weight compared to both other groups (NICUs with survival > P75: 26.27 ± 1.72 weeks and 831 ± 255 g vs. NICUs with survival P25-75: 26.47± 1.62 weeks [p<0.001] and 851 ± 256 g [p=0.005]; and vs. NICUs with survival <P25: 26.57± 1.67 weeks and 873 ± 255 g [pP75]).

Active perinatal care of very immature infants appears to improve outcomes at the border of viability and survival rates at higher gestational ages. However, long-term neurological outcome data are needed before recommendations for parental counselling should be reconsidered.

COI: Travel stipend from Chiesi
ID: 169

TITLE: STILLBIRTH OUTCOME BY MATERNAL NATIONALITY IN GREECE DURING THE YEARS OF ECONOMIC CRISIS: TRENDS AND RISK FACTORS

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CONTENT:

The perinatal mortality rate is a key population health indicator reflecting economic development, social equity and health care services within a population. Stillbirths constitute more than 70% of perinatal deaths in developed countries, including Greece. The recent economic crisis has been linked with declines in population health with the most vulnerable groups being disproportionately affected. However, evidence on the impact of the crisis on stillbirth rates is scarce and dubious. The aim of this study was to assess time trends of stillbirth rates in Greece during the pre-crisis (2004-2008) and crisis period (2009-2015) and explore stillbirth risk factors.

In this nationwide population study conducted in Greece, primary data on all births (N=1,276,816), out of which 5,023 stillbirths, during the period 2004-2015, were provided by the Hellenic Statistical Authority. Information was recorded for index child’s sex, birth order, birthweight and size at birth (small, appropriate or large for gestational age), prematurity, multiplicity, as well as for parental age, maternal nationality, place of residence, maternal marital status and maternal education. Stillbirth rates were calculated and time trends were assessed through Poisson and joinpoint regressions. Multiple adjusted logistic regressions and population attributable fractions (PAF) for stillbirths by maternal nationality were also undertaken.

The average stillbirth rate was 3.9 reaching a significantly higher 5.0/1,000 births/year rate among non-Greeks. Non-significant trends were noted for Greek (–0.5%, 95% confidence intervals (CI) -1.4%, +0.4%) and non-Greek mothers (+1.4%, 95% CI -0.5%, +3.3%); joinpoint regression showed non-significant time breaks. Male sex, multiple pregnancies, first and fourth birth, low maternal education, residency in rural areas, unmarried status, small or large for gestational age size at birth, as well as increased maternal age (≥35 years), were recognized as significant determinants of stillbirth outcome. After adjusting for possible confounders, the stillbirth risk increased significantly during the crisis versus the pre-crisis period [odds ratios (OR) for Greeks 1.70 (95% CI 1.57, 1.84), population attributable fraction (PAF) 24.0%; OR for non-Greeks 1.94 (95% CI 1.65, 2.28), PAF 27.7%].

During the 12-year study period, non-statistical, albeit of different direction, stillbirth trends among Greek and non-Greek mothers were observed. However, after adjusting for sociodemographic determinants, the period of the economic crisis (2009-2015) conferred a significantly higher stillbirth risk, especially among non-Greek mothers.

COI: None declared
ID: 217  

**TITLE:** ADVANTAGES IN RESPIRATORY OUTCOMES IN VERY-LOW-BIRTH-WEIGHT FEMALE INFANTS (24 TO 30 WEEKS) SEEM TO BE CONSISTENT THROUGHOUT GESTATIONAL AGE.

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**CONTENT:**

Several studies have shown differences in outcomes according to sex in Very-Low-Birth-Weight (VLBW) infants favoring females, but some of them suggest that differences disappear with increasing gestational age (GA). The aim of our study was to determine whether there are sex differences in respiratory morbidity, in mortality, and in survival without bronchopulmonary dysplasia in VLBW infants under 30 weeks GA, adjusting for perinatal risk factors, and whether these differences, if present, are consistent throughout different GA.

Retrospective analysis of prospectively collected data of VLBW infants, born at 240 to 306 weeks gestational age (GA) between January 2013 and December 2016 in the collaborative centers of the Spanish Neonatology Society (SEN1500) and in the South American Collaborative Neonatal (NEOCOSUR) Networks. The following patients were excluded: 173 infants (1.6%) who died in the delivery room, 467 (4.2%) with major congenital anomalies (74 of them dying in delivery room), and six infants with ambiguous genitalia or whose sex was not properly. Differences in proportions between sexes were compared by the Chi-square test, and survival without BPD throughout GA by the Cox proportional hazards regression model adjusting for confounding factors. Results are expressed as HR with 95% CI.

During the study period, 11,140 VLBW inborn infants were recorded in the study centers, 6,385 (57.3%) in the SEN1500 network and 4,755 (42.7%) in Neocosur. After exclusions, 10,568 patients were analyzed. Mean (SD) GA was 27.7 (1.8) weeks; birth weight 1023.1 (257.4) grams; male sex: 53.2%; multiple: 28.1%. Females received more antenatal steroids (at least one dose): 89.8% vs. 88% (p=0.003), and magnesium sulfate: 55.6% vs. 51.3% (p<0.001). Females were born more frequently by Caesarean section: 70.8% vs. 68.7% (p=0.016). After birth, males were intubated more frequently during resuscitation: 46.8% vs. 43.2% (p=0.001), and they received more postnatal steroids for BPD: 11.1% vs. 9.2 (p=0.02). The following Figure shows the incidence of respiratory distress syndrome (RDS), total time of invasive mechanical ventilation, survival and survival without BPD, specific by GA.

After adjusting for confounding factors, female infants exhibited a lower risk of RDS throughout all GA although it was statistically significant from 28 weeks GA on. Among those who need intubation, the total time of invasive mechanical
ventilation was shorter in females in almost all GA. They also had a consistent higher likelihood of survival and survival without BPD.

IMAGES:  
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COI: No conflicts of interest.
ID: 292

TITLE: MATERNAL CENTRAL ADIPOSITY AND INFANT BIRTH WEIGHT

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CONTENT:

Background: Obesity and overweight during pregnancy are associated with several adverse pregnancy outcomes for the mother and the infant. It is well known that central adiposity is a stronger predictor of obesity related health issues that peripheral adiposity in non-pregnant individuals. Currently, body mass index (BMI) is used for risk stratification of pregnant women, but BMI does not differentiate central from peripheral adiposity. It is suggested that central adiposity increases the risk of adverse pregnancy outcomes, and that central adiposity could be a better risk marker than BMI only. This study aimed to evaluate the relation between maternal central adiposity and infant birth weight.

Methods: Subcutaneous (SCF) and visceral fat (VF) depths were measured in healthy women subjected to routine antenatal ultrasound in gestational week 16-19 at Uppsala University hospital from January 2015 to December 2017. Maternal age (years), parity (first born or all other), smoking, BMI, in vitro fertilization (IVF), maternal country of origin (EU or non-EU), obstetric diagnoses, gestational age, and infant birth weight were obtained from the standardized antenatal, and obstetric medical records. We excluded women with gestational diabetes mellitus, pre-eclampsia and gestational hypertension. Only singleton and term infants were included. Visceral fat and SCF was modelled separately due to covariance. Adjustments were made for BMI, maternal age, parity and smoking.

Results: 2334 healthy women were included in the study. The women were between 16 and 44 years of age, 41.1 % were primiparous, and 39.1 % were either pre-obese or obese. Parity, IVF and maternal origin were all significantly associated with birth weight. Parous women and women born in EU gave birth to heavier children. Mothers who had gone through IVF gave birth to lighter children. Birth weight did not differ between non-smoking and smoking mothers. In a linear regression model adjusted for BMI, maternal age, parity and smoking, every 5-mm increase in VF predicted an increase in birth weight by 8.6 grams. Subcutaneous fat depth was not a predictor of birth weight.

Conclusion: High maternal VF depth at gestational week 16-19 is associated with an increase in infant birth weight. Thus, VF measuring could easily and inexpensively be added into the routine antenatal ultrasound in order to predict infant birth weight, and to help determine which obese and overweight women who should get extended surveillance during their pregnancy.

IMAGES:
https://www.eiseverywhere.com/eselectv3/v3/events/351149/submission/files/download?fileID=25be4bb3878b12c60143d0f9a270c65d-MjAxOS0wNSM1Y2UyNjY2YzIwMDk3

Table 1. Association between maternal SCF and VF depths and birth weight. Linear regression model.

COI: None declared.
ID: 334

TITLE: MORTALITY PREDICTION IN VERY LOW BIRTH WEIGHT NEONATES DURING HOSPITAL ADMISSION

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CONTENT:

New mortality predictive models in Spanish premature infants have been recently developed by our group. During hospital admission, causes of mortality vary depending when death occurs. Mortality predictive models exist for specific times during hospitalization (delivery room, 7th day, 28th day and 36 week’s postmenstrual age -Ambalavanam N, 2012). The aim of this study was to develop and validate a dynamic survival prediction model during hospitalization, integrating length-of-stay as a key variable, for preterm infants registered in the Spanish SEN1500 database.

Inclusion: Infants born alive with BW <1500g or GA <30 weeks without congenital defects or chromosomal disorders registered in SEN1500 database. Periods: Development (DP) (2009-12) and Validation (VP) (2013-15). Predictive mortality model: during hospital admission. Statistical analysis: dependent variable: hospital mortality. Independent variables: significant maternal, perinatal and neonatal data were used in multivariable regression models. Cut-off points for “death” and “no death” (Kappa index), Negative and Positive Predictive Values (NPV, PPV), accuracy and area under the curve (AUC) were calculated. This model is a composition of two sub-models alternatively applied before or after the 30th day of admission. Length-of-stay was used to evaluate time impact on patient’s outcome.

14953 newborns were included (DP=8734; VP=6219). 1688 of 2015 (84.8%) died during the 1st month of life. AUC for predicted mortality was 0.999 during the 1st month of life (95% CI: 0.998-0.999) (p<0.001) and 0.950 after 30 days of life (95% CI: 0.930-0.961) (p<0.001). The model showed a “very good” concordance (Kappa=0.86). Table 1 shows different prognostic cut-off points for “survival probability”, as well as NPV and PPV. Variables with the greatest impact on predicting mortality during all admission were Gestational age, Birth weight, multiple pregnancy, maternal steroids, Apgar-5 min and severe pneumothorax. During the first month of life variables related to death were necrotizing enterocolitis, severe infection and intraventricular hemorrhage. Cystic periventricular leukomalacia, severe anemia, and bronchopulmonary dysplasia were the outcomes related to death after 30 days of life.

A new mortality predictive model including main variables related to death and incorporating length of stay was developed and validated for preterm infants born in Spain. Application of continuous models of changing probability can improve individual mortality outcome estimation.

IMAGES:
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COI: None declared
ID: 753

TITLE: FOLLOW-UP OF THE REPRODUCTIVE OUTCOMES OF ADULTS WHO WERE BORN VERY PRETERM AND/OR VERY LOW BIRTH WEIGHT FROM 28 TO 35 YEARS OF AGE

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CONTENT:

Adults who were born very preterm (VPT) and/or with a very low birth weight (VLBW) within the Project on Preterm and Small for Gestational Age Infants in the Netherlands (POPS) cohort of 1983, showed significantly reduced reproductive rates compared to the national Dutch population at 28 years of age (females 23.2% vs 31.9% and males 7.4% vs 22.2% at least one livebirth) [1]. This study aimed to follow-up the reproductive outcomes of this cohort at 35 years of age.

The participants of the POPS cohort were retraced in the year 2018. Participants who returned a signed informed consent form received a link to the online POPS35 questionnaire about their Quality of Life, Employment & Burn-out symptoms and Reproductive Outcomes. Reproductive outcomes included reproductive rate, pregnancy wish, fertility problems, pregnancy complication and perinatal outcomes of their offspring, for example recurrence of preterm birth. These outcomes were also collected in term controls obtained through Facebook and also compared to national statistics and perinatal registries.

In this ongoing study, 351 POPS35 questionnaires are currently completed (37% of 955 surviving POPS cohort participants). In addition, 376 controls competed the same questionnaire. Preliminary analysis showed no difference in reproductive rates (at least one pregnancy) between the POPS participants and controls (both around 50%). Nevertheless, compared to the national statistics, POPS participants reported a lower mean number of children at 35 years and among females a significantly higher incidence of HDP (25%) and placental pathology (7%) compared to the national perinatal registry (11% and 1.5%). All these outcomes were comparable between POPS participants and controls.

These preliminary results suggest catch up of the delay in reproductive rate in adults born VPT and VLBW between 28 and 35 years of age, but still some differences with the Dutch population remain. These results should be interpreted with caution as they are still preliminary and may be confounded by selection bias due to selective non-response of those most handicapped, low educated and of male gender.

COI: This study was done for EU-project RECAP (www.recap-preterm.eu), funded by the European Commission; Horizon 2020; Grant Number: 733280. The authors declare no conflict of interest.
ID: 790

TITLE: TREATED CASES OF RETINOPATHY OF PREMATURITY - 5-YEAR DATA FROM THE RETINA.NET ROP REGISTRY

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CONTENT:

Retinopathy of Prematurity (ROP) is a potentially blinding disease in very preterm children. The incidence of ROP requiring treatment is relatively low in Germany, a fact that makes it difficult to analyse treatment data and outcomes. In order to overcome this limitation, the German Retina.net ROP registry was founded in 2012 with the aim to jointly collect and analyse treatment patterns and outcomes from ROP patients.

In the present study, changes in treatment patterns between 2011 and 2015 were analysed. Data from all children born between 2011 and 2015 who were entered into the database at the 12 participating German centres were included in the analysis. This cohort represents about 10-15% of children treated for ROP in Germany during the observation period.

Between 2011 and 2015, a total of 150 children (292 eyes) were registered in the database. Among them, stage II, 3+ was the most prevalent indication for treatment. While gestational age and birth weight remained stable over the years, the treatment patterns changed significantly during this period: in 2011, only 10% of eyes were treated with anti-VEGF drugs (bevacizumab or ranibizumab). In 2014 and 2015, 56% and 30% respectively were treated with anti-VEGF drugs. In all years, almost all eyes with AP-ROP and Zone I disease were treated with VEGF inhibitors, while the majority of zone II disease received laser. Recurrences happened more frequently and later in the group treated with anti-VEGF drugs in comparison to laser (23% recurrence at a mean of 60 days vs. 17% recurrence at a mean of 23 days). Regarding the perioperative complications, there was no difference between the two groups.

The presented data demonstrate a shift in treatment patterns towards an increasing use of anti-VEGF drugs for ROP. There is a selection bias towards the use of anti-VEGF drugs especially in the more aggressive stages of ROP, which needs to be taken into account when interpreting the data, especially when evaluating the frequency of recurrences. The risk for late recurrences after anti-VEGF treatment is of particular clinical significance.
COI:  S. Bemme: Novartis
K. Engelmann: Novartis, Bayer
A. Gabel-Pfisterer: Bayer
T.U. Krohne: Alimera Sciences, Bayer, Heidelberg Engineering, Novartis
B. Lorenz: Novartis, Bayer, Editas Medicine, Allergan Pharmaceuticals
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A. Stahl: Allergan, Bayer, Boehringer Ingelheim, Novartis, Recordati Rare Diseases
L. Wagenfeld: Bayer, Novartis, Alimera Sciences, Allergan
J.M. Walz: Novartis
T. Barth, M. Daniel, H. Breuß, D. Süßkind, V.C. Müller, S. Aisenbrey, A. Koutsonas: none
TITLE: IMPACT OF MATERNAL ETHNICITY ON PERINATAL OUTCOMES OF SMALL FOR GESTATIONAL AGE INFANTS

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CONTENT:

Maternal ethnicity has been linked to perinatal outcomes of premature infants. However, the relationship between maternal ethnicity and perinatal outcomes of small for gestational age (SGA) infants remains unclear. The objective of this study was to examine the perinatal and neonatal outcomes of SGA infants born to South Asian (SA)-born mothers, when compared to Australian or New Zealand (ANZ)-born mothers. A secondary aim was to compare the placental histological findings of SGA infants with those of ANZ infants.

Retrospective cohort study conducted at Monash Health, a large metropolitan hospital network in Melbourne, Australia. Maternal and neonatal data was collected for infants of all gestations, born SGA between 2013-2017 to SA or ANZ-born mothers. Rates of perinatal mortality and morbidities were measured including resuscitation and respiratory outcomes, conditions related to prematurity, and outcomes of term infants. Univariate and multivariate analysis was conducted to compare neonatal outcomes between groups. Secondary analysis of placenta macroscopic and histological findings between a subset of infants from the two groups was also done.

1018 SA and 959 ANZ SGA infants were included. SA babies were significantly older (median (IQR) 39(38-40) weeks) and heavier (2590(2310-2780) grams) compared to ANZ babies (38 (37-40) weeks) and 2480 (2059-2740) grams; p<0.001. There was no difference in perinatal mortality (0.5% vs. 0.9%; p=0.2). After correction for differences in demographics, SA SGA babies were 1.5 times more likely to develop neonatal hypothermia (CI 1.1 to1.8, p=0.001); but 2.5 times less likely to be born with a major congenital malformation (CI 0.2 to 0.6, p=0.001) and 1.5 times less likely to need gavage feeding (CI 0.4 to 0.9, p=0.02) as compared to ANZ SGA babies. There were also trends towards less need for resuscitation, and need for respiratory support in SA SGA babies. However, there were no significant differences seen on placental pathology in a subset of 171 SA infants and 140 ANZ infants.

Babies born SGA to south Asian mothers have a different perinatal and neonatal outcome profile as compared to SGA babies born to Australasian mothers. Reduced growth seems to be associated with a similar placental pathology, in these ethnically diverse populations. Further research into the influence of ethnicity on organogenesis and fat stores of SGA babies may be warranted.

COI: None declared
**ID:** 846  
**TITLE:** NEONATAL NOISE EXPOSURE AND NOISE REDUCTION DURING NEONATAL TRANSPORT: NOISE PROTECTION DURING NEONATAL HELICOPTER TRANSFERS  
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**CONTENT:**

Air transport provides for distant and time-critically ill and premature neonates. Air transfers can expose neonates to noise levels that may compromise health such as noise-induced hearing loss, autonomic disturbances, behavioural and cognitive instability. The current recommended safe environmental sound pressure levels (SPL) should not exceed 45dB (decibel) in neonatal intensive care units (NICU) or 60dB during transport. We measured noise during helicopter transfers and quantified the efficacy of noise protective equipment in a mannequin study. We also investigated the effects of noise protection equipment on oxygen saturation and heart rate of neonatal patients on helicopter transfers.

In the mannequin study, a 4-channel sound level meter (Svan958-A®) connected to 3 microphones measured SPL in decibel-A (dBA) from the external ear, inside the incubator and outside (helicopter cabin) during practise air transfers. This was repeated with the use of noise protective ear muffs(NPEM) and active noise canceling headphones(ANC). Similar methods were used for patient studies, using NPEM and ANC with additional pulse oximetry recording. All patients had noise protection during the single journey air transfers. The demographic data were collected on all subjects. SPL was continuously recorded from 3 positions along with the simultaneous recording of heart rate and oxygen saturation. All data were analysed using specialist software and SPSS v.25® was used for statistical analysis.

Noise (dBA) was represented as peak SPL (Lpeak) and total sound energy (Leq). The mannequin study: Mean Lpeak during transfers was 87±5(ear), 98±15(incubator) and 98±9(outside) and mean Leq was 74±5(ear), 86±14(incubator) and 86±10(outside).100±14% of cabin noise was detected at the mannequin ear, 85±10% was detected with NPEM and only 68±13% was detected with ANC. Paired sample t-test compared SPL of cabin with noise protection with p values<0.001 for Lpeak and Leq. The patient study: Noise protection was applied during the whole flight. 4 patients were recruited (2 NPEM and 2 ANC). NPEM group experienced harmful Lpeak of › 85dBA 82% of the time vs 36% in ANC group. O2 saturation were lower at SPL ›85dBA in NPEM group (92vs82, p<0.001) but higher in the ANC group (85vs94,p<0.001). Heart rate was lower if SPL ›85dBA in both; NPEM (166vs137, p<0.001) and ANC (127vs106, p<0.001).

Noise represented in Sound Pressure Level (SPL) measured at the patient ear during helicopter transfers exceeds safe levels and reached dangerous and hazardous levels >50% of the time. These cause changes to heart rate and oxygen saturation. The application of noise protection helps reduce noise exposure with ANC being an effective modality in reducing neonatal noise exposure during helicopter transfers. Further studies are currently in progress.

**IMAGES:**
https://www.eiseverywhere.com/eselectv3/v3/events/351149/submission/files/download?fileID=8a671f490d186bbf5fe7c4dc1376036c-MjAxOS0wNSM1Y2UyNjY2ZDBhN2RI

The application of Noise Protective Ear Muffs (NPEM) for a neonatal helicopter transfer.

**COI:** None declared
Title: Intensity of perinatal care for extreme preterm babies and outcomes at a higher gestational age

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Content:
Perinatal decision-making affects outcomes for extremely preterm (EP) babies (22–26 weeks gestational age (GA)): units with more active care have improved survival without increased morbidity. Such units may gain skills and expertise that mean babies at a higher GA also have better outcomes than if they were born elsewhere. We examine whether there are differences in survival and sensorimotor (blindness, deafness or cerebral palsy) disability at age 2 for babies born at 27-28 weeks GA in relation to the intensity of perinatal care (IoPC) provided to EP babies. We hypothesised there would be higher survival without increased morbidity for babies born in units with a higher IoPC for EP babies.

Fetuses from the 2011 French national prospective EPIPAGE-2 cohort, alive at maternal admission to a level 3 hospital and delivered at 27-28 weeks GA, were included. Sensorimotor disability and Ages & Stages Questionnaire (ASQ) result below threshold among survivors were primary and secondary outcomes. Survival and morbidity-free survival were also examined. IoPC level was based on birth hospital (3 groups using the ratio of 24–25 weeks GA babies admitted to neonatal intensive care to foetuses of the same GA alive at maternal admission). Multiple imputation was used for missing data; hierarchical logistic regression was used to account for births nested within centres. Sensitivity analyses used ratios based upon antenatal steroid usage, Caesarean section, and newborn resuscitation rates.

At 27-28 weeks, 633 of 747 fetuses (84.7%) survived to age 2 (179/214 in low, 210/249 in medium and 244/284 in high IoPC hospitals). There were no differences in sensorimotor disability (adjusted odds ratio (aOR) 2.02 (95% CI 0.66-6.13) and 1.68 (0.53-5.28) in medium and high compared to low IoPC hospitals) or ASQ below threshold (aOR 1.09 (0.59-2.01) in medium, 1.16 (0.62-2.16) in high IoPC hospitals). Units with different IoPC levels had unchanged survival (medium: aOR 0.96 (0.54-1.71); high: 1.12 (0.63-2.00)) and morbidity-free survival (medium: 1.09 (0.59-2.01); high: 1.16 (0.62-2.16)). Sensitivity analyses were consistent: aORs for sensorimotor disability in medium and high IoPC hospitals for antenatal steroids were 1.10 (0.35-3.42) and 1.16 (0.44-3.01), for Caesarean section 0.98 (0.40-2.40) and 0.49 (0.14-1.71), and for neonatal resuscitation 1.76 (0.59-5.25) and 1.46 (0.50-4.33).

We found no difference at 2 years of age in sensorimotor disability or presence of an ASQ below threshold for survivors born at 27-28 weeks GA in hospitals with differing IoPC for EP births. We also found no difference in overall survival or morbidity-free survival among fetuses alive at maternal admission to hospital. We conclude there is no evidence for an impact of the IoPC for EP babies on births at a higher gestational age.

COI: None declared