ID: 119

TITLE: ASSOCIATION BETWEEN SOCIOECONOMIC FACTORS AND NEURODEVELOPMENT OUTCOMES AT 1 AND 2 YEARS OF CORRECTED AGE IN VERY LOW BIRTH WEIGHT AT A MOTHER-INFANT HOSPITAL IN BUENOS AIRES, ARGENTINA.

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CONTENT:

Recently, the number of preterm and small for gestational age survivors has increased at Ramón Sardá Mother-infant Hospital. Factors such as growth, low birth weight and health outcomes are affected by adverse socioeconomic status in early childhood. The objective of this retrospective study was to analyze the association between socioeconomic factors and neurodevelopment outcomes at 1 and 2 years of corrected age (CA) in preterm babies with a birth weight less than 1500 grams, born between 2003 and 2013 at this hospital.

We conducted a retrospective study of infants included in the preterm follow up program between 2003 and 2013. Infants with congenital diseases and other morbidities were excluded. Socioeconomic factors: years of maternal education, unmet basic needs, monoparental family, unstable occupational status, adolescence and social insurance. The neurodevelopment score at 1 and 2 years of CA was binary encoded as adequate and inadequate. Other factors: sex, small for gestational age, hospital readmissions and breastfeeding. To evaluate the association between socioeconomic factors and the binary score of neurodevelopment Chi-square test and logistic regression were performed. Odds ratios were estimated.

A total of 405 infants were included for the first year analysis and 317 for the second one. Less than 7 years of maternal education, unmet basic needs, monoparental family, unstable occupational status, lack of breastfeeding at 6 months and small for gestational age were associated with lower neurodevelopment scores both at 1 and 2 years of CA (bivariate analysis, Mann Whitney U test, p<0.05).

Furthermore, small for gestational age (OR=2.72; 1.37-5.40; p=0.004), lack of breastfeeding at 6 months (OR=2.33; 1.39-4.00, p=0.001) and less than 7 years of maternal education (OR=3.35; 1.33-8.43; p=0.010) were found to be risks factors for an inadequate neurodevelopment outcome at 1 year of CA. However, only the unmet basic needs was found to be a risk factor for an inadequate neurodevelopment outcome at 2 years of CA (multivariate analysis, OR=1.84; 1.09-3.09; p=0.02).

Small for gestational age, lack of breastfeeding at 6 months and less than 7 year of maternal education were found to be risks factors for an inadequate neurodevelopment outcome at 1 year of CA. Only unmet basic needs was found to be a risk factor for an inadequate neurodevelopment outcome at 2 years of CA.

It is paramount to deepen the study of socioeconomic factors and life inequalities in order to understand vulnerability and its dimensions.

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COI: None declared
ID: 121

TITLE: ASSOCIATION BETWEEN SOCIOECONOMIC FACTORS AND GROWTH OUTCOMES AT 1 AND 2 YEARS OF CORRECTED AGE IN VERY LOW BIRTH WEIGHT BABIES AT A MOTHER-INFANT HOSPITAL IN BUENOS AIRES, ARGENTINA.

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CONTENT:

Recently, the number of preterm and small for gestational age survivors has increased at Ramón Sardá Mother-infant Hospital. Factors such as growth, low birth weight and health outcomes are affected by adverse socioeconomic status in early childhood. The objective of this retrospective study was to analyze the association between socioeconomic factors and growth outcomes at 1 and 2 years of corrected age (CA) in preterm babies with a birth weight less than 1500 grams, born between 2003 and 2013 at this hospital.

We conducted a retrospective cohort study of the infants included in the preterm follow up program between 2003 and 2013. Infants with congenital diseases and other morbidities were excluded. Socioeconomic factors: years of maternal education, unmet basic needs, monoparental family, unstable occupational status, adolescence and social insurance. The outcomes: Z scores of growth and underweight, short stature and microcephaly at 1 and 2 years of CA. Other factors: sex, small for gestational age, hospital readmissions and breastfeeding. Chi-square test and logistic regression were run for underweight, short stature, microcephaly and socioeconomic factors. Odds ratios were calculated.

A total of 405 infants were included for the first year analysis and 317 for the second one. Factors like small for gestational age, hospital readmissions, less than 7 years of maternal education and monoparental family were associated with lower growth Z scores outcomes both at 1 and 2 years of CA (bivariate analysis). Small for gestational age, less than 7 years of maternal education, female gender, hospital readmissions and monoparental family were associated with underweight, short stature and microcephaly (Chi-square test p<0.05). Less than 7 years of maternal education was the strongest factor associated with underweight (OR 10.40; 3.22-33.58; p<0.001), short stature (OR 4.46; 1.50-13.30; p=0.007) and microcephaly (OR 23.48; 2.67-206.42; p=0.004) at 2 years of CA (multivariate analysis).

Small for gestational age, years of maternal education, female gender, hospital readmissions and monoparental family were associated with underweight, short stature and microcephaly.

It is paramount to deepen the study of how socioeconomic factors and life inequalities influence childhood growth in order to understand vulnerability and its dimensions.

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COI: None declared
ID: 322

TITLE: THE EFFECTS OF EARLY TOUCHSCREEN USE ON NEURODEVELOPMENTAL OUTCOMES AT 24 MONTHS

AUTHORS: Triona Casey 1; Conal Wrigley 2; Dawn Fisher 3; Karen Kinsella 4; Teresa Berkery 5; Andrea Hemmingway 6; Leanna Fogarty 7; Prof Mairead Kiely 8; Prof Deirdre Murray 9.

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CONTENT:

Children under two years are spending increasing amounts of time on touchscreen devices, despite a lack of evidence on the impact of such use on later development. Whilst some reports suggest that fine motor skills may be improved by touchscreen use, a recent systematic review recommended reducing screen-based sedentary behaviour for young children. Our aim was to investigate the effects of early touchscreen use (18 months) on children’s later neurodevelopment (24 months), using a standardised psychometric tool targeting distinct developmental domains (cognition, language, motor skills).

Children were recruited as part of an ongoing birth cohort study. Parents of typically developing first born children were asked about their child’s touchscreen use at 18 months. We defined “touchscreen” as a mobile phone or tablet device, with “touchscreen use” including active (interactive games) or passive engagement (watching videos). Rate of use was logged as “Never”, “Occasionally”, “2-3 times per week” or “Daily”. Standardised developmental assessments were conducted with each child at 24 months using the Bayley Scales of Infant and Toddler Development, Third Edition (Bayley-III). The effects of previous touchscreen use at 18 months on Bayley-III scores at 24 months were examined (7 variables: 3 composite and 4 scaled scores across cognitive, language and motor domains).

Complete data was available for 72 children (41 Male; 31 Female). Children’s rate of touchscreen use at 18 months was reported as never (n=32), occasionally (n=33), 2-3 times per week (n=5) and daily (n=2). For analysis the groups were categorised as “No use” (n=32) and “Some use” (n=40). A trend to reduced scores were seen across all domains in those children with touchscreen exposure at age 18 months (Table 1). These differences were statistically significant in the areas of expressive language and composite motor score with an effect size of 0.25 and 0.24 respectively. Moreover, maternal education was not found to be associated with either touchscreen use or Bayley-III outcomes.

This study provides the first clear evidence of the hindering impact of touchscreen use at 18 months on expressive language skills at 24 months. Our study also demonstrates the negative effects of early touchscreen use on motor development at 24 months. The persistence of these detrimental effects on later development needs to be established.

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Comparison of 24 month Bayley-III neurodevelopmental outcomes for children with no touchscreen use and any touchscreen use at 18 months
COI: None declared
ID: 474
TITLE: NEONATAL AND NEURODEVELOPMENTAL OUTCOMES OF NEONATES AFFECTED BY EXTREME AND PROLONGED PREMATURE RUPTURE OF MEMBRANES IN MULTIPLE PREGNANIES.
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AFFILIATIONS: 1,2,3 Neonatal Unit, Cliniques Universitaires St Luc, Brussels, Belgium

CONTENT:

Extreme preterm premature rupture of membranes (PPROM) < 26 weeks occurs in up to 1 % of pregnancies. Multiple pregnancy is a major risk factor for PPROM, occurring at an earlier gestational age than in single pregnancy. Our goal is to describe neonatal and long-term neurological outcomes of extreme PPROM, which are poorly defined, by comparing PPROM and non-PPROM siblings of twin pregnancies.

This is a retrospective, single-center study (2011-2018), including 8 multiple pregnancies (7 twin and 1 triple) during which a single fetus experienced PPROM < 25 weeks and >14-days latency from birth and severe oligohydramnios (amniotic fluid index < 5). Neonatal complications (mortality, bronchopulmonary dysplasia (BPD) at 28 days and 36 weeks (mild/moderate/severe by Jobe’s classification), pulmonary hypertension (PH, defined as need for inhaled nitric oxide, iNO), intraventricular hemorrhage (IVH grade 1-4) and necrotizing enterocolitis (NEC) were compared between PPROM and non-PPROM siblings, as well as neurodevelopmental follow-up at 1, 2 and 3 years (4 pairs). Values are expressed in median (inter-quartile range). We used Chi-square test and Wilcoxon statistical tests.

Age at PPROM was 16 w (15-21). Latency was 53 d (37-74). 2 pregnancies resulted in stillbirths. Gestational age at birth was 28 w (25-30) for live births. Birth weight were 1045 (725-1575) versus 1120 g (797-1630). iNO was needed for 5/6 PPROM twin vs none in controls (p = 0,005). 2 siblings died < 48 h. There were 2 pneumothoraces in PPROM vs none in controls. Mild BPD occurred in 1 vs 3, moderate BPD in 1 vs 2 and severe BPD in 2 vs none. Respiratory support at 36 w was 60% vs 0% (p <0,05). IVH occurred in none of PPROM twins vs 1 in non-PPROM (grade III). Non surgical NEC occurred in 1 vs none. Neurodevelopmental follow-up was available for 4 pairs (table 1). There were no statistical differences between groups. A diagnosis of autism was established at 18 months for 2 siblings who were homozygous. 2 PPROM infants developed mild behavior disorder vs. none in the non-PPROM group.

Even though PPROM twins showed a greater incidence/severity of BPD and PH, we could not demonstrate significant differences in neurodevelopmental outcomes. Despite size and design limitations, our study supports offering conservative antenatal care and fully supportive postnatal management in extreme and prolonged PPROM in twin pregnancies. Larger multicenter studies are warranted in order to establish definite recommendations.

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Neurodevelopmental follow-up

COI: None declared
Concerns about preterm infants’ long-term outcome have arisen due to their increased survival. The availability of accurate tools for the early detection of infants at risk for negative outcome is of utmost importance. General Movements (GMs) assessment evaluates the integrity of the central nervous system. However, there is a limited understanding of how GMs’ trajectories may evolve over time.

We aimed to investigate GMs’ trajectories in a cohort of very low birth weight infants up to three months of corrected age (CA) in order to detect the GMs’ trajectories that might be addressed for early intervention and follow-up examination overtime.

We conducted an observational, longitudinal study. A total of 216 very low birth weight infants (birth weight <=1500 g) were enrolled. Serial GMs were recorded at 31±1, 35±1, 40±1 weeks of gestational age (GA) and at three months CA. Longitudinal GMs’ trajectories were described for each infant based on two evaluations from 31±1 to 40±1 weeks and compared with GMs at three months of CA. GMs’ trajectories were classified as following: Normal-Normal (N-N); persistence of poor repertoire (PR-PR); persistence of Cramped Synchronized GMs (CS-CS); Normal – Poor Repertoire (N-PR); Poor Repertoire – Normal (PR-N); Poor Repertoire – Cramped Synchronized (PR-CS); Cramped Synchronized – Poor Repertoire (CS-PR); Normal – Cramped Synchronized (N-CS); Cramped Synchronized – Normal (CS – N).

The most represented was the N-N trajectory (n=128), whereas the trajectories including CS were the less observed (PR-CS: n=5; CS-CS: n=4). Fifty infants showed a PR-PR trajectory; N-PR and PR-N trajectories included 12 and 17 infants, respectively. Infants showing N-N trajectory have fidgety movements at three months of CA in the majority of cases (92%). On the contrary, infants showing either a CS-CS or a PR-CS trajectory did not have fidgety movements in any case. Moreover, infants showing either a N-PR or a PR-PR trajectory appear to show fidgety movements only in half cases (50-52%). The N-N group presented less neonatal morbidities and had the shortest hospital stay.

Our results indicate the importance of evaluating GMs trajectories before term CA. Findings of N-N trajectories help clinicians in reassuring parents on normal neurodevelopment of their infants at three months of CA. CS-CS and PR-CS trajectories indicate the need for an early rehabilitation treatment. N-PR and PR-PR trajectories indicate the need for closer follow up in order to avoid delay in programming potential intervention programs.
ID: 554

TITLE: LONG-TERM HEALTH STATUS AND NEURODEVELOPMENTAL OUTCOME IN MONOAMNIOTIC TWINS

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CONTENT:

Monoamniotic twinning is one of the most lethal conditions in perinatal medicine, mainly due to complications related to cord entanglement. The long-term health status and neurodevelopmental outcome of monoamniotic twins is not known. The objective of this study is therefore to investigate the long-term health status and neurodevelopmental outcome in monoamniotic twins.

All monoamniotic twins born after 2004 in three tertiary medical centres, aged at least 2 years at time of inclusion, were eligible for this study. Perinatal information was gathered from medical records. We assessed the health status and neurodevelopmental outcome using one of the following related questionnaires: the Health Status Classification System for Preschool Children (HSCS-PS) for children between 2 and 5 year of age and the Health Utility Index (HUI) for children aged 5 years and older, both covering almost the same attributes. The outcome of the questionnaires was used to calculate an overall health score based on the HUI3 index.

Fifty-two monoamniotic twin pairs were identified of which 84 (80.8%) children were live born and survived up to time of the study. Of these, four twin-pairs (9.5%) were lost to follow-up. The survey response rate was 80.3% (61/76). The mean health score was 0.95 (±0.10, range 0.51-1.00). The majority of children (38/61, 63.2%) achieved the highest possible score (1.00). 6 respectively 3 children were classified suffering from moderate or severe disabilities (score <0.88 resp. <0.70). No significant differences in average overall health score were found between monoamniotic twins and Dutch control data (p=0.30), however, the average health score might be overestimated due to response shift in parents of monoamniotic twins.

Overall long-term health status and neurodevelopmental outcome in monoamniotic twins appears to be favourable, however, this might be an overestimation due to response shift in parents of monoamniotic twins. Further objective investigation of long-term outcome is needed to confirm this outcome.

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Long-term outcome, comparison to reference score
COI: None declared
Parents of very preterm (VPT) born infants report more mental health problems compared to parents of infants born at term. While previous research focused more on depression, anxiety symptoms may be more prevalent. Also, research has overlooked fathers. In the Netherlands, families of VPT infants are eligible to receive support from the ToP program, a responsive parenting intervention between discharge home and 12 months corrected age. The ToP program also includes specific intervention strategies targeting parental well-being. The aim of this study was to evaluate maternal and paternal anxiety and depression at discharge and at completion of the ToP intervention and their interrelationship.

In order to monitor parental mental health during the ToP program, mothers and fathers were asked to complete the Hospital Anxiety and Depression Scale (HADS) at the start (T0) and the end (T1) of the program. The HADS cut-off for clinical symptoms is 8 for both the anxiety and depression subscales. Families that participated in the ToP program between 2014 and December 2018 and gave consent to use data for scientific research were included. The level of anxiety and depression symptoms for mothers and fathers at both time points as well as the percentage in the clinical range were compared using t-tests and McNemar tests. Birthweight, gestational age and length of hospital stay (LOS) were also collected and examined as potential predictors.

At T0 (1 month post-term) 1454 mothers and 971 fathers and at T1 855 mothers and 439 fathers of 1234 singletons and 460 multiplets in the ToP program (mean gestational age = 29 3/7 weeks, mean birth weight = 1285 grams) filled in the HADS. Mothers and fathers scored significantly higher at T0 than T1 on anxiety and depression, and with higher rates in the clinical range on T0 (See also Table 1 for parents with complete data on both time points).

Mothers scored significantly higher on anxiety and depression than fathers at T0 and T1 (p < .05). Persistent clinical anxiety (at T0 and T1) occurred in mothers in 6.9% and in fathers in 3.2%, whereas 3.9% of mothers and 1.7% of fathers had persistent clinical depression. LOS was the most important clinical risk factor at T0 for maternal and paternal anxiety and maternal depression, but only paternal anxiety was still associated with LOS at T1.

Reported symptoms of anxiety and depression decrease in mothers and fathers who were supported by the ToP program during the first year after discharge. Mothers reported more symptoms of anxiety and depression than fathers, but rather low symptoms were found for mothers and fathers compared to other studies. This may indicate the importance of early screening and guidance of parental mental health during post-discharge parenting interventions.

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Mean scores and percentage above clinical level for parents who completed the HADS at both time points.
COI: none declared
**ID:** 659  
**TITLE:** EXTREME PRETERM PREMATURE RUPTURE OF MEMBRANES: NEONATAL AND LONG-TERM OUTCOMES  
**AUTHORS:** Bénédicte Van Grambezen 1; Catheline Hocq 2; Olivier Danhaive 3  
**AFFILIATIONS:** Neonatal Intensive Care Unit  
Universitary Hospital Saint-Luc  
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Belgium  

**CONTENT:**

Extreme preterm premature rupture of membranes (PPROM) is a rare pregnancy complication leading frequently to spontaneous miscarriage or extremely premature birth, with a mortality up to 70%, in part due to elective pregnancy termination. Little is known about long-term developmental outcomes of these patients. Our aim is to compare developmental outcome of surviving 16-24-week PPROM newborns with age-matched, unaffected infants.

Retrospective single-center study (period 2006-2018) comparing 2 groups. Group 1 (n=42): preterm infants with PPROM occurring 14 days between PPROM and delivery and oligohydramnios (amniotic fluid index < 5). Group 2 (n=42): sex- and gestational age-matched (±7 days) infants without PPROM. Data on mortality, intraventricular hemorrhage grade >2 (IVH), severe pulmonary hypertension (defined as inhaled nitric oxide treatment, iNO) and bronchopulmonary dysplasia (defined as respiratory support at 28 days, BPD) were collected as indicators of neonatal course severity. Developmental outcomes were assessed at 1, 2, 3 and 5 years by clinical examination and formal testing adapted to the infants’ age.

All babies received full antenatal corticosteroids course. Mean gestational age at birth was 29 ± 2 and 29 ± 2 weeks (mean ± SD, gp1 and gp2, p=0.96). Gp1 PPROM latency was 52.8 ± 24 days. Mean birthweight was 1301 ± 439 and 1110 ± 387 g (p=0.08). Gp1 mortality rate was 14.3% (gp2 included only survivors). IVH rates were 1/42 and 0/42. iNO rates were 25/42 (60%) vs. 0% (p<0.001). BPD rates were 26/35 (74%) vs. 16/35 (46%) (p<0.02). Results of Bayley testing were normal at 1 and 2 years for both groups (table 1). At 3 years, 10 PPROM children and 6 control children had a normal development and a delay was observed for respectively 3 and 2 children. At 5 years, although follow-up rate had decreased to 20%, outcomes were similar in both groups except for language evaluation: 5 children in the PPROM group had a delay vs. 2 in the controls (p<0.05).

Despite a more severe neonatal course, long-term outcomes appear to be similar in both groups for most items except language. Although this study has size and design limitations, our results support conservative and optimized pre- and postnatal care to these high-risk patients. Future, appropriately sized studies with a longer follow-up are warranted in order to confirm these preliminary results.

**IMAGES:**  
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**COI:** None declared
ID: 744

TITLE: THE MODERATE AND THE LATE PRETERM INFANT: COMPARISON ON NEONATAL OUTCOMES

AUTHORS: Laschi Elisa 1; Nanni Giuliana 1, Giordano Maurizio 2, Muraca Maria Carmela 1, Palombo Daniele 1, Buonocore Giuseppe 1; Perrone Serafina 1

AFFILIATIONS: 1 Department of Molecular and Developmental Medicine, University of Siena, Siena, Italy
2 School of Medicine, Federico II University of Naples, Naples, Italy

CONTENT:

Moderate preterm (MPT, 32-33 weeks gestational age-GA) and late preterm infants (LPT, 34-36 wks GA) represent over 80% of preterm births, but are overall less known than those born at term and less studied than those born at lower gestational age. Since the maturational development takes place along the gestation continuum, each week of GA at birth can affect differences in the neonatal outcomes of these infants and thus influence their management.

An observational study on all live births of GA 32-36 weeks in a single III level center (Azienda Ospedaliera Universitaria Senese) in the years 2016-2017 was conducted. The aim of our study was to evaluate the short-term outcomes of MPT and LPT, with particular reference to the differences between the two groups related to care management and the frequency of the most common neonatal pathologies. The data concerning the obstetric history and the neonatal course were collected from the medical records of hospitalization; the auxological parameters at birth and discharge were calculated with reference to INeS neonatal anthropometric charts.

Study population consisted of 176 infants (7.9% of all births; 34 MPT, 142 LPT). Significant differences emerged between the two groups regarding the following outcomes: need for resuscitation at birth (70.5% vs 29.5%); hospitalization in Neonatal Intensive Care Unit (NICU; 97% vs 35.9%); duration of admission to NICU (10.5 vs 1.5 days) and of overall hospitalization (28 vs 15 days); neonatal respiratory distress syndrome (85.2% vs 23.9%); need for any respiratory support (94.1% vs 45.7%); intraventricular hemorrhage of any degree (52.9% vs 9.8%); jaundice treated with phototherapy (55.8% vs 16.9%); iron supplementation (79.4% vs 7%); antibiotic therapy (100% vs 43.6%). Auxological parameters were significantly different between the groups, as well as the need for any nutritional support, the beginning of enteral feeding and the time to reach enteral and oral autonomy (p<0.0001).

Moderate preterm infants are at greater risk of unfavorable neonatal outcomes compared to late preterm infants. In fact, the moderate preterms seem to behave more similarly to those born with a lower gestational age compared to the more "mature" LPT, although they also need particular attention and greater assistance, especially with regard to feeding methods.

COI: None declared