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CORRESPONDENCE

Letter to the editor: FIGO good practice recommendations on modifiable causes of iatrogenic preterm birth

We read with great interest the FIGO good practice recommendations on modifiable causes of iatrogenic preterm birth.[1] Avoiding iatrogenic prematurity should be one of the main goals of all obstetricians. The balance between maternal and fetal morbidity/mortality is sometimes difficult to establish; especially with regard to pregnancy-induced hypertension, a condition that carries a considerable risk for the mother. Our concern is especially true for low- and middle-income settings, where surveillance and early diagnosis of pre-eclampsia represent a great challenge.

In this paper, the authors state that patients with pregnancy-induced hypertension—i.e. gestational hypertension—should be offered delivery from 39 weeks onward. The paper uses as references HYPITAT I[2] and II[3] trials, and an individual patient meta-analysis by Bernardes et al.[4] However, the HYPITAT I trial concludes that induction of labor should be advised for women with mild hypertensive disease (gestational hypertension and mild pre-eclampsia) after 37 weeks of gestation, and the HYPITAT II trial studies patients before 37 weeks of gestation.[2,3] The conclusion of the Bernardes et al. meta-analysis states that the risk of neonatal distress respiratory syndrome is reduced when induction of labor is implemented at or after 36 weeks of gestation.[4]

Following these important studies, several associations worldwide updated their recommendations, suggesting induction of labor for patients with pre-eclampsia or gestational hypertension at or after 37 weeks of gestation.[5–9]

In light of this evidence, we would like to kindly ask the authors for some clarification about the reasons for such a recommendation.

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Linked article: This correspondence comments on the Special Article from Valencia et al.: https://obgyn.onlinelibrary.wiley.com/doi/full/10.1002/ijgo.13857

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APPENDIX A

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