On the basis of these study results, the authors concluded that platelet counts in all women decrease throughout pregnancy, but severe thrombocytopenia is rare. For women with counts <100,000/mm³ who do not have preeclampsia or a preexisting disorder associated with thrombocytopenia, a cause other than pregnancy should be considered.

A total of 9117 women were included in the final study cohort. Of those, 259 experienced SMM (2.91%). SPM occurred in 5.5%. The median number of scheduled antenatal visits was 9. Almost half of all patients had >110% of the recommended number of visits based on the duration of their pregnancy, while 12.2% had fewer than 80% of recommended visits, and 17.0% began antenatal care late (at 14 wk or later). Attending fewer than 50% of recommended visits was associated with SPM [adjusted odds ratio (aOR), 1.43 to 3.59] and SMM [aOR, 2.40 (1.38 to 4.17)]. There was no association between late initiation of care and SMM or SPM. First or second trimester ultrasounds were missed by 16% of patients and the first trimester ultrasound was missed by 21.6%. According to the mAPNCU-1 index, 18.5% had inadequate antenatal care and according to the mAPNCU-2 index, 34.6% had inadequate antenatal care. There was an association between inadequate antenatal care according to index and SPM [aOR, 1.37 (1.05 to 1.80)] but not SMM.

Independent of other characteristics, women who do not receive adequate antenatal care are at a higher risk of severe maternal and perinatal morbidity. Greater attention and intervention should be given to at-risk women to improve outcomes.

**Perinatal and Maternal Morbidity and Mortality Among Term Singletons Following Midcavity Operative Vaginal Delivery Versus Cesarean Delivery**

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Recently, to reduce the cesarean delivery rate, the use of operative vaginal delivery has been advocated by the American College of Obstetricians and Gynecologists and the Society for Maternal-Fetal Medicine. There is uncertainty, however, in the balance of risks and benefits between cesarean delivery and operative vaginal delivery. Previous research has lacked information on pelvic station, a measure of the descent of the fetal head with respect to the maternal ischial spines. Operating at the midcavity station requires the greatest skill compared with outlet or lowcavity forceps procedures. This study aimed to quantify the effect of...
operative vaginal delivery at midcavity station on maternal and perinatal mortality and morbidity compared with cesarean delivery.

This population-based cohort study included all term singleton cesarean or midcavity operative vaginal deliveries in the second stage of labor in British Columbia, Canada. The province’s Perinatal Data Registry was used to obtain data. Deliveries were stratified by those with dystocia and those with fetal distress. Midcavity operative vaginal delivery was defined to include delivery by forceps, vacuum and sequential instruments in cases when the head was engaged, and the leading point of the fetal skull was above the +2-cm station and below the 0-cm station. An intention-to-treat framework was used. The 2 primary outcomes were composite severe perinatal morbidity/mortality and composite severe maternal morbidity. Secondary outcomes included postpartum hemorrhage, respiratory distress in the infant, and birth and obstetric trauma. Adjusted rate ratios (ARR) and 95% confidence intervals (CIs) were estimated using multinomial propensity scores and multivariable log-binomial regression models.

Of the 10,901 deliveries included in the study, 5057 attempted midcavity operative vaginal deliveries or cesarean deliveries with dystocia and 5844 attempted midcavity operative vaginal or cesarean delivery with fetal distress. Compared with cesarean delivery, attempted midcavity operative vaginal delivery was associated with higher rates of severe perinatal morbidity and mortality in deliveries with dystocia (forceps ARR, 2.11; 95% CI, 1.46-3.07; vacuum ARR, 2.71; 95% CI, 1.49-3.15; sequential ARR, 4.68; 95%). Midcavity operative vaginal delivery was associated with higher rates of severe maternal morbidity/mortality (forceps ARR, 1.57; 95% CI, 1.05-2.36; vacuum ARR, 2.29; 95% CI, 1.57-3.36). In cases with fetal distress, there was an increase in severe maternal morbidity following attempted midcavity delivery using forceps (ARR, 2.34; 95% CI, 1.54-3.56) and an increase in severe perinatal morbidity/mortality after attempted midcavity vacuum delivery (ARR, 2.34; 95% CI, 1.04-1.61).

These results show that, compared with cesarean delivery, attempted midcavity operative vaginal delivery was associated with an increased risk of severe perinatal morbidity/mortality as well as severe maternal morbidity among term singleton deliveries in the second stage of labor. Encouraging the reduction of cesarean delivery by increasing the use of operative vaginal delivery could cause increases in severe maternal and perinatal morbidity.