Elective Induction of Labor in the 39th Week of Gestation Compared With Expectant Management of Low-Risk Multiparous Women

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1. The authors excluded from analysis women with one of number of medical problems or prior pregnancy or delivery complications to identify a low-risk multiparous cohort. Do you agree with their inclusion and exclusion criteria? Are there any other medical or prior pregnancy conditions for which you would have excluded patients from this study?

2. Discuss the authors’ choice to exclude women with spontaneous labor or indicated induction of labor between 39 0/7 and 39 4/7 weeks of gestation, as opposed to including them in the expectant management group. What sort of bias could this introduce into the study? How could this bias be minimized?

3. Discuss the merits and drawbacks of using a composite primary outcome for this study.

4. Discuss the main findings of this study. Discuss the difference between relative risk and absolute risk reduction.

5. Discuss the differences in baseline characteristics between the two groups and how the authors attempted to account for these differences.

6. Review the main findings of the A Randomized Trial of Induction Versus Expectant Management (ARRIVE) trial (see Grobman MA et al. N Engl J Med 2018;379:513–23). Discuss the similarities and differences between the findings in this study and the ARRIVE trial.

7. Discuss whether the results of this study will change how you practice obstetrics. If so, how? If not, why not?

8. Discuss how a decision at your intuition to induce all multiparous patients at 39 weeks of gestation would affect workflow and resources. Is this something your institution could accomplish at this time?

9. How would you counsel a low-risk multiparous woman who desires induction of labor at 39 weeks of gestation? How would you counsel one who did not want to be induced at 39 weeks of gestation?