

Reply to: Letter to the Editor: Administration of Antenatal Corticosteroids: Optimal Timing



We sincerely thank the authors of the letter to the editor for their interest in our work. The recommendations in the guidelines of the WAPM are almost identical to those in the German guideline on the prediction, prevention, and therapy of preterm birth [1, 2, 3, 4]. However, beyond 34+0 weeks of gestation, we definitely see no indication for the application of ACS. According to the numbers from the ALPS trial, the NNT to prevent one patient with BPD is 1:200 [5]. Otherwise, these children can be very well managed with high-flow nasal cannula and surfactant, if necessary.

In the present work, we have tried to provide the reader with a decision-making corridor that allows for optimizing the timing of ACS administration under various clinical settings beyond the guidelines mentioned above. While ACS administration is always indicated in women with PPROM, severe preeclampsia, fetuses with absent enddiastolic flow in the umbilical artery, or placental bleeding, great caution is warranted in patients with asymptomatic cervical insufficiency or preterm labor and a long cervix (≥ 15 mm).

Perhaps in the future the administration of ACS even at 30 weeks of gestation will be at stake. As cohort studies show a significant effect on IVH is very unlikely when ACS is administered beyond 30 weeks of gestation. The small effect on mortality before discharge beyond 30 weeks of gestation is clinically irrelevant with an NNT of approximately 1:800 [6]. We agree with our colleagues Dagklis and Sen that further research work is urgently needed in this important field of perinatology for the benefit of the women and children entrusted to our care.

Conflict of Interest

The authors declare that they have no conflict of interest.

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