Revision Urged to Guidelines on Caffeine in Pregnancy

Doctors should advise pregnant women and women planning to become pregnant to abstain completely from caffeine, according to a new narrative review in BMJ Evidence Based Medicine. “For the wellbeing of mothers and babies, health authorities are well-overdue to take a more realistic and responsible position in relation to maternal caffeine consumption,” the report’s author, Professor Jack E. James of Reykjavik University in Iceland, said in an email. “In short, caffeine should be avoided altogether during pregnancy.” The American College of Obstetricians and Gynecologists (ACOG) and several other health authorities state that moderate consumption of caffeine in pregnancy is not harmful, with some, including ACOG, defining this amount as less than 200mg daily. In the UK, “Based on current scientific opinion, the Food Standards Agency (FSA) advises pregnant and breast-feeding women not to have more than 200mg of caffeine over the course of a day, which is roughly two mugs of instant coffee or one mug of filter coffee,” the FSA said. The US Department of Agriculture (USDA) defers to physicians in its 2015-2020 Dietary Guidelines for Americans, stating: “Women who are capable of becoming pregnant or who are trying to, or who are pregnant, and those who are breastfeeding should consult their health care providers for advice concerning caffeine consumption.” Eighty-two percent of pregnant women in the US, and 91% in France, report consuming caffeine daily, James notes in his report. Caffeine easily crosses the placenta, he added, and is known to affect neural processes, including brain networks that control respiration and heart function. He analyzed 48 observational studies and meta-analyses of maternal caffeine consumption reporting at least one of six negative outcomes: miscarriage; stillbirth, low birthweight/smaller for gestational age; preterm birth; childhood acute leukemia and childhood overweight and obesity. Thirty-seven observational studies reported 42 separate findings, including 32 showing increased risk of harm due to caffeine in all outcomes except preterm birth, while 10 didn’t find

Webinar: Investigating Gut Health and the Microbiome of Premature Babies

Health professionals are invited to take part in a webinar called Building a Better Baby Biome: Caring for our Babies and their Bugs. Featured Speaker: Dr Katherine Gregory. The event is Thursday, September 17 at 11 am ET. During this webinar, Dr Katherine Gregory will discuss:

- Intestinal biology during early life
- The relationships between microbes and host cells
- Clinical factors that impact the establishment of the intestinal microbiome early in life
- Child health outcomes that are influenced by gut health and the intestinal microbiome
- Opportunities to therapeutically manipulate the intestinal microbiome to improve health outcomes

Registration and Complete Event Details: https://bit.ly/3gv8Ctz

Obtain High Quality Hearing Screening Results in the Shortest Possible Time

The Webinar on Newborn Hearing Screening is free and takes place on September 15, 12:00 pm (CST). Presented by: Kathy Murphy, MA, Newborn Screening Product Manager, MAICO Diagnostics, you’ll learn to explain why early identification of congenital hearing loss is important; name the two techniques used to screen newborns for hearing loss; describe the basic physiology of the auditory system’s response to the two screening methods; identify at least two environmental conditions that can make hearing screening challenging and ways to control them; explain the role of baby state on the hearing screening process; and list at least two “tips & tricks” to employ to achieve high quality screening results in the shortest time. Registration link: https://bit.ly/2EML1rs
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an association or were inconclusive. Out of 17 meta-analyses, 14 found associations between caffeine and miscarriage, stillbirth, low birth weight and/or small for gestational age and childhood acute leukemia. “Certainly, there is no evidence to suggest that caffeine benefits either mother or baby. Therefore, even if the evidence were merely suggestive, and in reality it is much stronger than that, the case for recommending caffeine be avoided during pregnancy is thoroughly compelling,” James said. “It is important for the public to understand that caffeine is not the benign substance it is often portrayed to be. Unfortunately, the position of many health authorities to date has been disappointing in this regard,” he added. “The idea that there is a safe level of maternal caffeine consumption is a myth that is strongly at odds with the scientific evidence. This accepting attitude towards caffeine and pregnancy must change.” In an emailed statement, ACOG said that it does not plan to change its guidelines at present. “Our guidance remains that moderate caffeine consumption, less than 200 mg per day, does not appear to be a major contributing factor in miscarriage or preterm birth,” Dr Christopher Zahn, MD, ACOG’s vice president of Practice Activities, said. “ACOG’s clinical guidance is based on a thorough expert review of the most current evidence and is routinely reviewed every 18-24 months. ACOG Committee Opinion, ‘Moderate Caffeine Consumption During Pregnancy’ was reaffirmed this year,” he added. “While this study will likely be included in the next review, there is nothing that warrants immediate change to the current guidance.”

**Black Newborns Less Likely to Die When the Treating Physician Is Also Black**

While research has shown that Black newborns in the US die at three times the rate of white newborns, a new study suggests that those numbers might improve when the race of the physician is concordant with the child’s. Based on data from 1.8 million births between 1992 and 2015, researchers found the in-hospital death rate among Black newborns was one third lower when these babies were treated by a Black physician, rather than a white one, according to the results published in the Proceedings of the National Academy of Sciences. The research doesn’t hold the key to why concordance might be beneficial to Black infants, said study coauthor Rachel Hardeman, Blue Cross Endowed Professor of Health and Racial Equity at the University of Minnesota-Twin Cities School of Public Health, in Minneapolis. “That’s the million-dollar question,” Hardeman said. “What we know from previous research is that there are issues around racism and implicit bias and that when physicians are short on time or in stressful situations, they are much more likely to rely on implicit biases.” To take a closer look at whether patient-physician concordance could make a difference in Black newborn survival, Hardeman and her colleagues modeled data from the State of Florida’s Agency for Healthcare...
Administration, which provides a census of patients admitted to Florida hospitals. Those data include detailed information on both the mother and the newborn, including race; comorbidities; outcomes; and the name, specialty certifications, and date of licensure of the treating physician. While the database did not include the physician’s race, the researchers determined that from publicly available photos. For their analysis, the researchers only included data on Black and white newborns and Black and white physicians. Overall, they found the raw mortality rate for white newborns was 289 per 100,000 births, while the raw mortality rate for Black newborns was 784 per 100,000 births. When the researchers analyzed newborn death rates by race of treating physician, they found that under the care of a white physician, Black newborns experienced 430 more fatalities per 100,000 births than white newborns. Under the care of Black physicians there was a big difference: there were 173 more fatalities per 100,000 births among Black newborns compared to white newborns. That’s a difference of 257 deaths per 100,000, the authors note.

When the researchers looked specifically at white newborns treated by white physicians, they did not find a similar benefit from concordance. Ultimately, the researchers determined that the “mortality penalty” for Black newborns is 39% lower under the care of a Black physician than under a white physician.

**Federal Investigation Finds Hospital Violated Patients’ Rights**

A prominent women’s hospital here violated patients’ rights by singling out pregnant Native American women for COVID-19 testing and separating them from their newborns without adequate consent until test results became available, according to a federal investigation disclosed to New Mexico In Depth and ProPublica. Lovelace Women’s Hospital did not admit to any wrongdoing but reported that the practice has been halted. Hospital officials submitted a plan to fix problems identified by investigators, including a promise to conduct internal audits to ensure compliance with state and federal regulations and COVID-19 screening guidance. “The Department of Health will assure that the plan of correction is fully and effectively enacted,” said New Mexico Secretary of Health Kathyleen Kunkel, the state’s highest-ranking public health official. “The Division of Health Improvement will be conducting an unannounced onsite survey to verify compliance.” Investigators with the state Health Department, who are contracted to conduct site surveys for the US Centers for Medicare and Medicaid Services, or CMS, launched their inquiry after an article by New Mexico In Depth and ProPublica reported that the hospital had targeted Native American mothers for COVID-19 testing based on their tribal-area ZIP codes, then separated them from their newborns while awaiting test results. All patients were screened upon arrival at the hospital with forehead temperature checks and standard questionnaires. But starting in late April, according to the report, patients with home ZIP codes on the hospital’s list were treated as “persons under investigation” and tested for COVID-19. That practice stopped May 28, investigators were told — one week after New Mexico In Depth and ProPublica first approached a hospital official about newborns being
separated from Native American mothers. The practice, while meant to stop the spread of COVID-19, was described by clinicians and health care ethicists as racial profiling. Isolating expectant mothers as though they had the virus created a stressful birth experience, a clinician noted. Separating newborns from mothers awaiting lab test results denied them early skin-to-skin contact and breastfeeding, which studies have shown can affect bonding. Investigators concluded that the hospital failed to protect patients’ rights by implementing an “informal policy to target patients that live on Native American reservations for COVID testing, and [to] separate mother and baby while test results were pending, and did not provide clear options for these patients to request or refuse COVID testing and separation from their babies.”

**Small NY Study: Mother-Baby Transmission of COVID-19 Not Seen**

All infants born to a cohort of 31 COVID-19–positive mothers tested negative for the virus during the height of the New York surge, according to a study out of New York-Presbyterian Hospital. “It is suggested in the cumulative data that the virus does not confer additional risk to the fetus during labor or during the early postnatal period in both preterm and term infants,” concluded Jeffrey Perlman, MB ChB, and colleagues in Pediatrics. But other experts suggest substantial gaps remain in our understanding of maternal transmission of SARS-CoV-2. “Much more needs to be known,” Munish Gupta, MD, and colleagues from Beth Israel Deaconess Medical Center and Harvard Medical School, Boston, said in an accompanying editorial. The prospective study is the first to describe a cohort of U.S. COVID-19–related deliveries, with the prior neonatal impact of COVID-19 “almost exclusively” reported from China, noted the authors. They included a cohort of 326 women who were tested for SARS-CoV-2 on admission to labor and delivery at New York-Presbyterian Hospital between March 22 and April 15th, 2020. Of the 31 (10%) mothers who tested positive, 15 (48%) were asymptomatic and 16 (52%) were symptomatic. Two babies were born prematurely (one by Cesarean) and were isolated in negative pressure rooms with continuous positive airway pressure. Both were moved out of isolation after two negative test results and “have exhibited an unremarkable clinical course,” the authors reported. The other 29 term babies were cared for in their mothers’ rooms, with breastfeeding allowed, if desired. These babies and their mothers were discharged from the hospital between 24 and 48 hours after delivery. “Visitor restriction for mothers who were positive for COVID-19 included 14 days of no visitation from the start of symptoms,” noted the team. They added “since the prepublication release there have been a total of 47 mothers positive for COVID-19, resulting in 47 infants; 4 have been admitted to neonatal intensive care. In addition, 32 other infants have been tested for a variety of indications within the unit. All infants test results have been negative.” The brief report outlined the institution’s checklist for delivery preparedness in either the operating room or labor delivery room, including personal protective equipment, resuscitation, transportation to the neonatal intensive care unit, and early postresuscitation care. “Suspected or confirmed COVID-19 alone in an otherwise uncomplicated pregnancy is not an indication for the resuscitation team or the neonatal fellow,” they noted, adding delivery room preparation and management should include contact precautions. “With scrupulous attention to infectious precautions, horizontal viral transmission should be minimized,” they advised.