Nifedipine Faster, Safer Than Magnesium Sulfate

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Miami Beach — Oral nifedipine is a faster acting and safer tocolytic than magnesium sulfate is, findings of a recent randomized study suggest.

A total of 192 women who presented between 24 and 34 weeks' gestation with contractions and cervical change or ruptured membranes were enrolled in the study. Of those randomized to receive nifedipine, significantly fewer achieved uterine quiescence (12 hours of six or fewer contractions per hour and no further cervical change within 48 hours), compared with the magnesium sulfate group (72% vs. 87%), Dr. Deirdre J. Lyell reported at the annual meeting of the Society for Maternal-Fetal Medicine.

However, in those who achieved quiescence, nifedipine acted within 6 hours vs. 8 hours for magnesium sulfate, and 34% of patients in the nifedipine group experienced side effects, compared with 65% in the magnesium sulfate group, said Dr. Lyell of Stanford (Calif.) University.

No side effects were significantly increased with nifedipine, compared with magnesium sulfate, although there was a trend toward greater risk for headache with nifedipine. Serious side effects such as shortness of breath were significantly more common with magnesium sulfate, and the three cases of pulmonary edema seen in this study all occurred in the magnesium sulfate group. Neonatal outcomes did not differ significantly between the two groups; birth weight, composite neonatal morbidity, and individual morbidity were similar, but neonates exposed to magnesium sulfate spent a slightly higher number of days overall in neonatal intensive care, Dr. Lyell noted.

An analysis of failed tocolysis in this study showed that 12 patients failed magnesium sulfate and 28 failed nifedipine. However, of 11 patients with continued contractions who were switched to an alternative tocolytic, all were in the nifedipine group. This finding raises the question of whether there was a physician bias against nifedipine in this unblinded study, she said.

"Interestingly, the majority of magnesium sulfate failures delivered within 40 hours vs. only 30% in the nifedipine group," she said, adding that time to delivery was significantly shorter in those with magnesium sulfate failure. Nifedipine is increasingly used as a tocolytic and was associated in two small previous studies with fewer side effects than magnesium sulfate. ■

Lupus Treatment Advised Despite Pregnancy Concern

Snowmass, Colo. — Lupus treatment should not be discontinued in anticipation of a pregnancy, Dr. W. Joseph McCune said at a symposium sponsored by the American College of Rheumatology.

Terminating drug treatment results in flares, and it is now clear that "there is really nothing worse for a lupus pregnancy than a flare, either immediately before the pregnancy or during the pregnancy," said Dr. McCune, director of rheumatology outpatient services at the University of Michigan, Ann Arbor.

The use of hydroxychloroquine during pregnancy in lupus patients is receiving increased interest from specialists, he said.

Instead of cessation of therapy, many physicians are trying to continue their patients on a corticosteroid (when necessary) and hydroxychloroquine, with informed consent and disclosure that the drug is known to cross the placenta.

Hydroxychloroquine is a drug that is not the most potent agent for resolving manifestations of lupus, but one that is very good at preventing serious disease developments and flares, Dr. McCune said.

Antimalarials have a number of potentially beneficial side effects, such as improving glucose tolerance, noted Dr. McCune, who previously reviewed and reported on evidence suggesting that antimalarials positively affect both cholesterol levels and thrombosis in lupus patients with increased cardiovascular risk.

There have been no apparent adverse fetal effects, and "in general, the experience has been that there have been no difficulties using this drug," in reports of some 300 lupus patients treated with hydroxychloroquine during pregnancy, he said.

—Timothy F. Kirn