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IN DEPTH

What are the benefits and harms of bedrest for complications of pregnancy?

Evidence-based answer
Bedrest does not reduce the rate of miscarriage or preterm birth, nor does it improve outcomes in women with multiple pregnancies (SOR: A, meta-analyses). Evidence is insufficient to determine whether bedrest improves outcomes in pregnant women with hypertension. Bedrest during pregnancy is associated with negative psychosocial effects (SOR: B, secondary outcomes in RCTs) and an increase in thromboembolic events (SOR: B, cohort study).

Evidence summary
A Cochrane review of the effect of bedrest on preventing miscarriage identified 2 RCTs with 84 women. One study included 23 women with viable pregnancies between 7 and 14 weeks who had experienced vaginal bleeding within the previous 24 hours. The second study included 61 women with a history of vaginal bleeding before the 8th week of gestational age. There was no significant difference in the risk of miscarriage in the bedrest group compared with the group that did not have bedrest (risk ratio [RR] 1.5; 95% CI, 0.92–2.6).

A Cochrane review of bedrest in singleton pregnancies for preventing preterm birth found only one RCT with 1,266 women that assessed clinical outcomes in women at high risk of preterm birth who were prescribed bedrest during the second or third trimester in the hospital or at home. High-risk pregnant women were identified by a risk scoring system. The intervention group was prescribed bedrest at home (n=432) and the control group (n=834) either received a placebo medication (n=412) or no intervention (n=422). Preterm birth before 37 weeks was not significantly different between the 2 groups (7.9% in the intervention group vs 8.5% in the control group; RR 0.92; 95% CI, 0.62–1.4).

CONTINUED
A Cochrane review of the effect of routine prophylactic bedrest in the hospital for women with a multiple pregnancy for prevention of several outcomes identified 7 RCTs that included 713 women and 1,452 babies. The gestational age of the women at the time of hospitalization varied among the studies from as early as 24 weeks to a late as 34 weeks. There was no reduction in preterm birth or perinatal death in the bedrest groups when compared with women who were encouraged to continue their usual activities at home. Nor was there a difference in the number of low-birthweight infants (<2,500 g) or very-low-birthweight infants (<1,500 g).

Substantial heterogeneity was noted related to perinatal death and stillbirth that was not explained by trial quality. One trial provided information about what women thought about their care in the routinely hospitalized group. Six percent “appreciated admission” and 18% found hospitalization for bedrest “psychologically distressing” (no statistical comparison provided). A Cochrane review of bedrest for hypertension during pregnancy identified 4 small RCTs including 449 women. Two trials of 145 hospitalized women with gestational ages of 26 to 38 weeks and with proteinuric hypertension compared strict bedrest with allowing the women to move around the hospital ward. There were no differences in maternal or fetal outcomes (eg, preeclampsia, abruption, preterm delivery). Two trials of 304 women with gestational ages of 28 to 38 weeks and with nonproteinuric hypertension compared some bedrest in the hospital with routine activity at home. In one of these trials (218 women) there was a decreased risk of severe hypertension (RR 0.58; 95% CI, 0.38–0.89) and a reduction in risk of preterm birth (RR 0.53; 95% CI, 0.29–0.99). In one trial of 86 women, the bedrest group chose not to have the same management during future pregnancies, if given a choice (RR 3.0; 95% CI, 1.4–6.3). A retrospective study examined the risk of thromboembolic events in 192 hospitalized women on bedrest for preterm labor or preterm premature rupture of membranes. The prevalence of thromboembolic events in women on bedrest was 16 per 1,000, compared with 0.8 per 1,000 in the pregnant control group not on activity restriction (P<.0015).