Prophylactic Indomethacin and Intestinal Perforation in Extremely Low Birth Weight Infants

**Authors:** John Kelleher, MB, BCH, Ariel A. Salas, MD, Ramachandra Bhat, MD, Namasiyavam Ambalavanan, MD, Shampa Saha, PhD, Barbara J. Stoll, MD, Edward F. Bell, MD, Michele C. Walsh, MD, MS, Abbot R. Laptook, MD, Pablo J. Sanchez, MD, Seetha Shankaran, MD, Krisa P. VanMeurs, MD, Ellen C. Hale, RN, BS, CCRC, Nancy S. Newman, RN, M. Bethany Ball, BS, CCRC, Abhik Das, PhD, Rosemary D. Higgins, MD, Myriam Peralta-Carcelen, MD, MPH, and Waldemar A. Carlo, MD, for the GDB Subcommittee, Eunice Kennedy Shriver National Institute of Child Health and Human Development Neonatal Research Network

**Abstract**

**Objective:** Prophylactic indomethacin reduces severe intraventricular hemorrhage but may increase spontaneous intestinal perforation (SIP) in extremely low birth weight (ELBW) infants. Early feedings improve nutritional outcomes but may increase the risk of SIP. Despite their benefits, use of these therapies varies largely by physician preferences in part because of the concern for SIP.

**Methods:** This was a cohort study of 15,751 ELBW infants in the Eunice Kennedy Shriver National Institute of Child Health and Human Development Neonatal Research Network from 1999 to 2010 who survived beyond 12 hours after birth. The risk of SIP was compared between groups of infants with and without exposure to prophylactic indomethacin and early feeding in unadjusted analyses and in analyses adjusted for center and for risks of SIP.

**Results:** Among infants exposed to prophylactic indomethacin, the risk of SIP did not differ between the indomethacin/early-feeding group compared with the indomethacin/no-early-feeding group (adjusted relative risk [RR] 0.74, 95% confidence interval [CI] 0.49–1.11). The risk of SIP was lower in the indomethacin/early-feeding group compared with the no indomethacin/no-early-feeding group (adjusted RR 0.58, 95% CI 0.37–0.90, P = .0159). Among infants not exposed to indomethacin, early feeding was associated with a lower risk of SIP compared with the no early feeding group (adjusted RR 0.53, 95% CI 0.36–0.77, P = .0011).

**Conclusions:** The combined or individual use of prophylactic indomethacin and early feeding was not associated with an increased risk of SIP in ELBW infants. Pediatrics 2014;134:e1369–e1377
Prophylactic indomethacin during the first 3 days after birth in extremely low birth weight (ELBW) infants (birth weight ≤1000 g) decreases the incidence of severe intraventricular hemorrhage and patent ductus arteriosus (PDA). However, administration of indomethacin soon after birth in preterm infants may be associated with an increased risk for spontaneous intestinal perforation (SIP) or necrotizing enterocolitis. The question of feeding intolerance or increased SIP or feeds without evidence of increased enteral feedings and to determine if a trial is feasible, we undertook this retrospective study. The Eunice Kennedy Shriver National Institute of Child Health and Human Development Neonatal Research Network (NRN) showed that indomethacin treatment concurrent with enteral nutrition and SIP. The incidence of SIP in ELBW infants is 6%. A large case-control study that compared 633 infants with SIP with 581 control infants matched by gestational age, birth weight, and gender showed that exposed to indomethacin during the first 3 days after birth was associated with a higher risk for SIP compared with control infants (odds ratio [OR] 1.86, 95% confidence interval [CI] 1.4–2.5, P < .0001). A retrospective study of ELBW infants in the Eunice Kennedy Shriver National Institute of Child Health and Human Development Neonatal Research Network (NRN) showed that indomethacin treatment of a PDA but not the prophylactic use of indomethacin was associated with a higher risk for SIP (adjusted OR 1.61, 95% CI 1.25–2.08, P < .05). However, 3 randomized controlled trials and a retrospective cohort study of premature infants treated with indomethacin showed that neither SIP nor NEC was associated with the indomethacin exposure. Although the presence of enteral nutrition has been studied as a risk factor for development of NEC, studies have not shown an association between enteral nutrition and SIP. A case-control study and a randomized controlled trial have shown that enteral feeding concurrent with treatment of a PDA with indomethacin results in fewer days to reach full enteral feeds without evidence of increased feeding intolerance or increased SIP or necrotizing enterocolitis. The question of whether ELBW infants who receive prophylactic indomethacin should concurrently receive enteral nutrition or have their feeds withheld temporarily because of the risk of SIP remains unanswered. In the absence of a randomized controlled trial to test the safety and efficacy of prophylactic indomethacin treatment concurrent with enteral feedings and to determine if a trial is feasible, we undertook this retrospective study. The Eunice Kennedy Shriver National Institute of Child Health and Human Development Neonatal Research Network (NRN) showed that prophylactic indomethacin treatment concurrent with early enteral nutrition decreases the incidence of SIP. The GDB cohort included prophylactic indomethacin and early enteral nutrition during the first 24 hours after birth (yes/no, I+I–) and any enteral nutrition during the first 3 days after birth (yes/no, E+E–). The GDB includes data on the administration of indomethacin for any prophylaxis purposes within the first 24 hours after birth. Indomethacin for the purpose of closing a PDA (ie, treatment) is recorded separately within the database. There were 4 study cohorts based on prophylactic indomethacin and early enteral feeding status: (1) group I+E+, infants who received prophylactic indomethacin (I+) during the first 24 hours and any enteral feeding (E+) during the first 3 days after birth; (2) group I+E–, infants who received prophylactic indomethacin (I+) during the first 24 hours and did not receive enteral feeding (E–) during the first 3 days after birth; (3) group I–E+, infants who did not receive prophylactic indomethacin (I–) during the first 24 hours but received enteral feeding (E+) during the first 3 days after birth; and (4) group I−E–, infants who did not receive prophylactic indomethacin (I–) during the first 24 hours and did not receive enteral feeding (E–) during the first 3 days after birth. The I–E– group was the nonexposed referent group for comparisons unless otherwise specified to examine the interaction of feeding and indomethacin.

METHODS

Study Design

This was a retrospective 2-by-2 factorial cohort study of 2 neonatal exposures: (1) prophylactic intravenous indomethacin initiated during the first 24 hours after birth and (2) early enteral nutrition defined as any feeding administered during the first 5 days after birth. Data pertaining to indomethacin treatment, feeding during the first 3 days after birth, and other demographic and perinatal variables were collected prospectively as previously described.

Population and Exposures

The study population included 15,751 ELBW (birth weight 401–1000 g) infants who survived to at least 12 hours after birth within the member NICUs of the NRN during the study period 1999–2010. This study period was selected to represent a period when the practice of prophylactic indomethacin was increasingly prevalent based on the results of 2 trials in ELBW infants during the 1990s. The primary exposures examined within the GDB cohort included prophylactic intravenous indomethacin during the first 24 hours after birth (yes/no, I+/I–) and any enteral nutrition during the first 3 days after birth (yes/no, E+/E–). The GDB includes data on the administration of indomethacin for any prophylaxis purposes within the first 24 hours after birth.
follow-up, severe NDI in surviving infants at 18- to 22-month follow-up, indomethacin or ibuprofen treatment of PDA, and the need for surgical PDA treatment. NEC was defined according to the modified Bell staging criteria. Secondary nutritional outcomes included number of days to reach full enteral feeds, days of parenteral nutrition, and days to regain birth weight. Additional secondary outcomes included proven NEC with or without surgical treatment occurring anytime beyond day 14 after birth and SIP without NEC occurring anytime beyond day 14 after birth. The study had missing outcome data for some infants. There were 13 infants with SIP for whom the specific date of documentation of SIP was missing. In addition, there were 61 infants for whom the cause of death between 12 hours and 14 days after birth was missing. These missing outcome data resulted in slight differences in population denominators for the clinical outcomes shown in Table 2.

Survivors were evaluated at 18 to 22 months’ corrected age and received a comprehensive neurodevelopmental examination that included a neurologic examination and the administration of the Bayley Scales of Infant and Toddler Development, Second Edition (Bayley II) for children born from 1999 to 2005 and the Bayley Scales of Infant and Toddler Development, Third Edition (Bayley III) for children born from 2006 to 2010. For infants born from 1999 to 2005, severe NDI at 18 to 22 months’ corrected age was defined as having any of the following: Bayley II Mental Developmental Index <70 (≥2 SD below the mean), Bayley II Psychomotor Developmental Index <70, moderate to severe cerebral palsy, deafness (presence of hearing aids in both ears), and/or blindness (no useful vision in either eye). For infants born from 2006 to 2010, severe NDI was defined as having any of the following: Bayley III cognitive composite score <70 Modified Gross Motor Function Classification level ≥2,23 deafness (hearing impairment), and/or blindness (no or some functional vision in either eye).

**Statistical Analyses**

The NRN enrollment includes ~1500 ELBW infants per year in the GDB. Over the 12-year study period, it was estimated that there would be a total population of 18,000 infants. A previous NRN publication has shown that 29% of these patients receive prophylactic indomethacin. It was estimated that ~14% of ELBW infants may have died before receiving any prophylactic indomethacin. This resulted in an expected study population of 16,500 infants who were eligible to receive prophylactic indomethacin and any enteral feeding within the first 3 days after birth. The α was predefined as .05. The incidence of SIP was 6% and 5% in both the indomethacin (n = 601) and placebo control groups (n = 601), respectively, in the Trial of Indomethacin Prophylaxis in Preterms. It was estimated that for the comparison of I+E+ versus I+E− to detect an absolute increase in the incidence of SIP from 5% to 7.2% there would be a power of 80%. The study hypothesis was that the combined exposure to prophylactic indomethacin and early feeding (any feeds ≤3 days after birth) increases the risk for SIP within 14 days after birth in ELBW infants from 5% to ≥6% absolute risk (ie, by ≥20% relative risk [RR] increase).

Baseline demographic and perinatal characteristics of the 4 groups of newborns (I+E+, I+E−, I−E+, and I−E−) were analyzed by χ² for categorical variables (surfactant, antepartum hemorrhage, Apgar scores, race, etc) and by Wilcoxon test for continuous variables (birth weight, gestational age). Both unadjusted and adjusted analyses were performed to ascertain the effect of the 4 groups (I+E+, I−E+, I−E−, and I+E−) on the primary outcome of SIP within 14 days and all the secondary outcomes. Unadjusted analysis was performed by using χ² tests for categorical outcomes and Wilcoxon test for continuous outcomes. Adjusted analysis was performed using multivariate logistic regression analysis and Poisson regression models with robust variance estimators.

The model was adjusted for covariates including gestational age, birth weight, male gender, race, antenatal corticosteroid administration, surfactant administration, small for gestational age (birth weight <10th percentile for gender and gestational age as determined from growth curves by Alexander et al), and 5-minute Apgar score. The analyses were also adjusted for site.

Unadjusted and adjusted risk ratios comparing the risk of each of the exposure groups (I+E+, I−E+, I−E−) with nonexposure group (I−E−) for the primary outcome of SIP within 14 days and all the secondary outcomes were estimated. In addition, the adjusted risk ratio comparing early feeding and no early feeding groups among infants exposed to indomethacin (I−E+ vs I−E−) was estimated. SAS Version 9.2 (Cary, NC) was used for all statistical analyses. Denominators reported reflect missing values.

**RESULTS**

During the period of 1999–2010, 20,655 ELBW infants were enrolled in the NRN GDB registry (Fig 1). Among these infants, 15,751 ELBW infants survived >12 hours after birth and received enteral nutrition. Baseline demographic and clinical characteristics are shown in Table 1. Among infants exposed to prophylactic indomethacin, the risk of SIP did not differ between the I−E− and I−E− groups (RR 0.74, 95% CI 0.49–1.11, P = .1467). The rate of SIP was lower in the I−E+ relative to the I−E− referent group (RR 0.58, 95% CI 0.37–0.90, P = .0159, Table 2). The unadjusted rate of SIP was increased in the I−E+ group relative to the I−E− referent group (RR 1.31, 95% CI 1.08–1.57, P = .0051), but this was not significant in the adjusted
analysis (RR 0.79, 95% CI 0.60–1.04, \(P = .0960\)). However, early enteral feeding in the absence of prophylactic indomethacin (I−E+) was associated with a significantly lower risk of SIP when compared with the I−E− referent group (RR 0.53, 95% CI 0.36–0.777, \(P = .0011\)).

Prophylactic indomethacin with early feeding was associated with lower death or severe NDI at 18- to 22-month follow-up (I+E+: RR 0.86, 95% CI 0.77–0.95, \(P = .0045\)) when compared with those infants who received prophylactic indomethacin but not early feeding. Early enteral feeding regardless of prophylactic indomethacin was associated with significantly fewer days to reach full enteral feed and fewer total numbers of days of parenteral nutrition (both \(P < .001\), Table 3).

**DISCUSSION**

This study provides observational data that the combined administration of prophylactic indomethacin during the first 24 hours after birth and any enteral nutrition during the first 3 days was not associated with increased SIP when compared with infants who did not receive prophylactic indomethacin and early feeding. Infants who received any enteral feeding during the first 3 days after birth in the absence of prophylactic indomethacin had a lower risk of SIP compared with infants in the no prophylactic indomethacin/no-early-feeding group. Among infants exposed to indomethacin, the adjusted risk of SIP did not differ significantly between those who received enteral nutrition during the first 3 days compared with those who did not receive early feeding. Early enteral feeding regardless of use of prophylactic indomethacin was associated with lower rates of death or severe NDI at 18- to 22-month follow-up (I+E+ and I−E+, both \(P < .001\)) when compared with those ELBW infants who never received either prophylactic indomethacin and any early enteral nutrition (I−E−).

SIP occurs predominantly in ELBW infants, with the diagnosis often based on clinical findings. Among SIP infants who undergo surgery, histopathologic features are distinct from NEC and are characterized by focal intestinal perforations, typically in the ileum, without evidence of mucosal ischemic injury or intestinal inflammation.26 Numerous risk factors have been associated with SIP including prematurity, low birth weight,27 early indomethacin treatment with or without concurrent early postnatal corticosteroid administration,4,7 indomethacin treatment of a PDA later than 24 hours after birth,7 being outborn from a tertiary-level NICU, treatment with pressors, presence of a PDA, fetal inflammatory response, antenatal maternal antibiotic use, infectious agents, and intrauterine growth restriction.27 A meta-analysis showed that antenatal corticosteroids are not associated with SIP.28 A case-control study of 2105 infants identified the following risk factors for SIP: being outborn from a tertiary level NICU (mother less likely to have received antenatal corticosteroids), treatment with

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**FIGURE 1** Selection of the study cohorts.
either dopamine or dobutamine within 14 days before SIP, the diagnosis of a PDA and treatment with hydrocortisone during the first 3 days after birth. Another case-control study showed that infants with SIP were more likely than control infants matched for birth weight and gestational age to have evidence of fetal inflammatory response defined as acute vasculitis of the fetal placental surface or umbilical perivasculitis (funisitis). Mothers of infants with SIP were more likely than controls to have received antibiotics before or at the time of delivery. There is, however, a lack of strong evidence to establish a definitive infectious mechanism for the etiology of SIP. There is a lack of strong evidence to support the theory.

### TABLE 1 Baseline Characteristics of Study Cohorts

<table>
<thead>
<tr>
<th>Characteristic</th>
<th>I+E+ n = 1186</th>
<th>I+E− n = 4688</th>
<th>I−E+ n = 3128</th>
<th>I−E− n = 6749</th>
<th>p</th>
</tr>
</thead>
<tbody>
<tr>
<td>Gestation, wk, median (p25, p75)</td>
<td>26 (25, 27)</td>
<td>25 (24, 26)</td>
<td>27 (26, 29)</td>
<td>28 (25, 27)</td>
<td>&lt;.001</td>
</tr>
<tr>
<td>Birth wt, g, median (p25, p75)</td>
<td>820 (700, 910)</td>
<td>750 (641, 865)</td>
<td>670 (780, 945)</td>
<td>766 (630, 876)</td>
<td>&lt;.001</td>
</tr>
<tr>
<td>Race</td>
<td>White, n/total (n%)</td>
<td>Black, n/total (n%)</td>
<td>Male gender, n/total (n%)</td>
<td>Vaginal delivery, n/total (n%)</td>
<td>5 min Apgar, median (p25, p75)</td>
</tr>
<tr>
<td>Characteristic</td>
<td>I+E+ n = 1182 (51)</td>
<td>2645/4561 (57)</td>
<td>603/1182 (51)</td>
<td>2547/4562 (56)</td>
<td>7 (6, 8)</td>
</tr>
<tr>
<td></td>
<td>I+E− n = 1186 (51)</td>
<td>2663/4561 (57)</td>
<td>603/1182 (51)</td>
<td>2547/4562 (56)</td>
<td>7 (6, 8)</td>
</tr>
<tr>
<td></td>
<td>I−E+ n = 4651 (52)</td>
<td>3507/4561 (72)</td>
<td>603/1182 (51)</td>
<td>2547/4562 (56)</td>
<td>7 (6, 8)</td>
</tr>
<tr>
<td></td>
<td>I−E− n = 4674 (52)</td>
<td>3507/4561 (72)</td>
<td>603/1182 (51)</td>
<td>2547/4562 (56)</td>
<td>7 (6, 8)</td>
</tr>
</tbody>
</table>

Denominators vary to reflect missing values. p25, 25th percentile, p75, 75th percentile. I−E− is the baseline referent group for all comparisons.

### TABLE 2 Clinical Outcomes*

<table>
<thead>
<tr>
<th>Outcome</th>
<th>I+E+ n = 1186</th>
<th>I+E− n = 4688</th>
<th>I−E+ n = 3128</th>
<th>I−E− n = 6749</th>
<th>aRR (95% CI)</th>
</tr>
</thead>
<tbody>
<tr>
<td>SIP during first 14 d after birth</td>
<td>32/1182 (3)</td>
<td>177/4673 (4)</td>
<td>35/3117 (1)</td>
<td>207/6705 (3)</td>
<td>0.32 (0.37–0.90)*</td>
</tr>
<tr>
<td>SIP during day 14 after birth</td>
<td>8/1185 (0.7)</td>
<td>52/4684 (1)</td>
<td>25/3117 (0.8)</td>
<td>116/6742 (2)</td>
<td>0.42 (0.23–0.93)</td>
</tr>
<tr>
<td>Deaths: 12 h–14 d</td>
<td>148/4674 (3)</td>
<td>74/3119 (2)</td>
<td>287/3119 (9)</td>
<td>1037/6714 (16)</td>
<td>1.05 (1.03–1.08)</td>
</tr>
<tr>
<td>Death before discharge</td>
<td>146/1165 (12)</td>
<td>742/4674 (16)</td>
<td>287/3119 (9)</td>
<td>1037/6714 (16)</td>
<td>1.05 (1.03–1.08)</td>
</tr>
<tr>
<td>NEC with intestinal perforation during first 14 d after birth</td>
<td>2/1185 (0.2)</td>
<td>15/4684 (0.3)</td>
<td>11/3117 (0.4)</td>
<td>32/6742 (0.5)</td>
<td>1.04 (0.10–1.19)</td>
</tr>
<tr>
<td>Death or severe NDI at 18- to 22-mo follow-up</td>
<td>335/902 (37)</td>
<td>1754/3608 (49)</td>
<td>620/2036 (31)</td>
<td>2476/5202 (48)</td>
<td>0.63 (0.75–0.91)</td>
</tr>
<tr>
<td>Severe NDI in survivors at 18- to 22-mo follow-up</td>
<td>184/751 (25)</td>
<td>995/2849 (35)</td>
<td>342/1758 (20)</td>
<td>1389/4125 (34)</td>
<td>0.71 (0.61–0.83)****</td>
</tr>
<tr>
<td>Indomethacin or ibuprofen treatment of PDA</td>
<td>236/1184 (20)</td>
<td>1332/4555 (29)</td>
<td>813/3128 (28)</td>
<td>3403/6747 (50)</td>
<td>1.15 (1.13–1.20)****</td>
</tr>
<tr>
<td>Surgery for PDA</td>
<td>72/1185 (6)</td>
<td>566/4687 (12)</td>
<td>235/3128 (7)</td>
<td>1438/6746 (21)</td>
<td>0.42 (0.32–0.55)****</td>
</tr>
<tr>
<td>Proven NEC with or without surgical treatment after day 14 after birth</td>
<td>114/1186 (10)</td>
<td>461/4685 (10)</td>
<td>239/3128 (8)</td>
<td>587/6743 (8)</td>
<td>1.24 (0.98–1.55)</td>
</tr>
</tbody>
</table>

Denominators vary to reflect missing values. p25, 25th percentile, p75, 75th percentile. I−E− is the baseline referent group for all comparisons. * Concerning missing outcome data for infants, there were 13 infants (I+E+ = 1, I+E− = 4, I−E+ = 1, and I−E− = 7) with SIP in whom the specific date of documentation of SIP was missing. In addition, there were 61 infants (I+E+ = 2, I+E− = 11, I−E+ = 10, and I−E− = 37) for whom the cause of death was age 12 h and 14 d after birth was missing. ** Concerning the outcomes of NEC with intestinal perforation during first 14 d after birth and SIP after day 14, the adjusted analysis does not converge if center is included because the prevalence rates are low for these outcomes. Therefore, for these 2 outcomes, RR is adjusted for all other covariates except center.
that infants with intrauterine growth restriction have increased risk of SIP.27

Several studies have examined the association of indomethacin treatment in infants and either SIP12,4,7,11,12 or NEC with intestinal perforation1,2,7,10 with inconsistent results. The Trial of Indomethacin Prophylaxis in Preterm infants2 and a randomized trial by Ment et al4 reported no significant difference between the treatment and control groups for the outcomes of NEC or SIP. Prophylactic indomethacin was the intervention in both trials. A meta-analysis that included both of these trials showed no difference for the outcomes of NEC or SIP concerning treatment with prophylactic indomethacin compared with control groups.1 A trial of dexamethasone and/or hypercapnia within the first 12 hours after birth reported that indomethacin treatment in ELBW infants during the first 14 days after birth was associated with increased risk of SIP.28 Indomethacin use alone17 or in combination with postnatal dexamethasone28 or dexamethasone15,29 may be associated with SIP. Some studies have shown that early indomethacin administration within the first 12,6,24 hours,29 or 3 days1 after birth was associated with SIP. However, a retrospective of 11 960 ELBW infants in the NRN showed that indomethacin administration for PDA treatment after 24 hours after birth, but not prophylactic indomethacin, was associated with increased risk of SIP (adjusted OR 1.61, 95% CI 1.25–2.08, P < .05).7 The association of postnatal corticosteroid use as a risk factor for increased rate of SIP in ELBW infants treated with prophylactic indomethacin has been examined in 2 randomized controlled trials.28,29 ELBW infants who received concurrently prophylactic indomethacin and either hydrocortisone28 or dexamethasone29 had an increase in SIP in these trials.

A randomized controlled trial11 and a case–control study28 have examined the safety and efficacy of indomethacin and concurrent enteral feeding. A study by Clyman et al in 177 premature infants comparing trophic feeds at 15 mL/kg/day versus no feeds during indomethacin or ibuprofen PDA treatment reported that infants fed during treatment required 3 to 4 fewer days to reach 120 mL/kg/day of enteral feeds without evidence of increased feeding intolerance or increased SIP or necrotizing enterocolitis.11 Our study in contrast to that of Clyman et al examined prophylactic rather than therapeutic indomethacin in relation to early enteral nutrition. We did not examine the interaction of ibuprofen and early enteral feeding concerning SIP. An additional strength of our observational study is the large multicenter population with prospectively collected data concerning SIP. A limitation of this study, common to all nonrandomized clinical studies, is that although statistical models can adjust for known confounders (birth weight, gestational age, etc), they do not adjust for variables not included in the model but evident to the clinician. These variables may have influenced the decision to initiate or withhold feeds. The finding that any enteral feeding during the first 3 days after birth in the absence of prophylactic indomethacin was associated with a lower risk of SIP as compared with infants who did not receive prophylactic indomethacin and early feeding may reflect a selection bias. This finding of less SIP and improved chance of survival without severe neuro-developmental impairment in those ELBW infants who received early feeds may represent a bias. Infants who were not fed early were of lower birth weight and gestational age, more likely to be male, less likely to have had antenatal corticosteroids, more likely to have received surfactant, and more likely to have a PDA ligature. Early feeding among ELBW infants may be a marker for infants who are less ill during the first 3 days of life.30

Published studies reported that administration of prophylactic indomethacin to ELBW infants during the first 24 hours after birth reduced severe IVH and PDA1–3 and that early feedings were associated with decreased duration of parenteral nutrition and fewer days to achieve full enteral feeds and may have a protective effect regarding reduction of illness severity in ELBW infants.31 This study shows that concurrent administration of prophylactic indomethacin and early enteral feeding is associated with a lower risk of SIP in ELBW infants. This provides supporting observational data to refute the practice of withholding feeds while infants receive prophylactic indomethacin.

ACKNOWLEDGMENTS

The National Institutes of Health and the Eunice Kennedy Shriver National Institute of Child Health and Human Development (NICHD) provided grant support for the NRN’s GDB and Follow-up Studies. Data collected at participating sites of the NICHD NRN were transmitted to RTI International, the data-coordinating center (DCC) for the network, which stored, managed, and analyzed the data for this study. On behalf of the NRN, Dr. Abhik Das (DCC Principal Investigator) and Dr. Shampa Saha (DCC Statistician) had full access to all the data in the study and take

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**TABLE 3 Nutritional Clinical Outcomes**

<table>
<thead>
<tr>
<th>Outcome</th>
<th>I+E+ n = 1198</th>
<th>I+E– n = 4888</th>
<th>I+E+ n = 3128</th>
<th>I+E– n = 6749</th>
</tr>
</thead>
<tbody>
<tr>
<td>Days to reach full enteral</td>
<td>19 (14, 29)*</td>
<td>27 (19, 39)</td>
<td>16 (11, 25)*</td>
<td>26 (18, 38)</td>
</tr>
<tr>
<td>feeds (p25, p75), median</td>
<td></td>
<td></td>
<td></td>
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</tr>
<tr>
<td>Days of parenteral nutrition</td>
<td>18 (13, 33)*</td>
<td>28.5 (18, 44)**</td>
<td>17 (10, 29)*</td>
<td>29 (18, 44)</td>
</tr>
<tr>
<td>(p25, p75), median</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Days to regain birth wt</td>
<td>11 (7, 15)*</td>
<td>11 (7, 16)*</td>
<td>10 (7, 13)*</td>
<td>11 (8, 16)</td>
</tr>
<tr>
<td>(p25, p75), median</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

I+E– is the baseline referent group for all comparisons and for significance of P values; p25, 25th percentile; p75, 75th percentile. *P < .001; **P < .01.
responsibility for the integrity of the data and accuracy of the data analysis.

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Friedman, MA; Cincinnati Children's Hospital Medical Center, University Hospital, and Good Samaritan Hospital (U10 HD27853, M01 RR8084): Kurt Schibbler, MD, Edward F. Donovan, MD, Jean J. Steichen, MD, Kimberly Yolton, PhD, Barbara Alexander, RN, Kate Bridges, MD, Cathy Grisby, BSN, CCRC, Marcia Worley Mersmann, RN, Holly L. Mincey, RN, BSN, Jody Hessling, RN, Teresa L. Gratton, PA; Duke University School of Medicine, University Hospital, Alamance Regional Medical Center, and Durham Regional Hospital (U10 HD40492, M01 RR30): Ronald N. Goldberg, MD, C. Michael Cotten, MD, MHS, Kathy J. Auten, MSHS, Kimberly A. Fisher, PhD, FNP-BC, IBCLC, Katherine A. Foy, RN, Kathryn E. Gustafson, PhD, Melody B. Lohmeyer, RN, BSN; Emory University, Children's Healthcare of Atlanta, Grady Memorial Hospital, and Emory University Hospital Midtown (U10 HD27851, M01 RR39): David P. Carlton, MD, Ira Adams-Chapman, MD, Ellen Hale, RN, Sheena Carter, PhD, Maureen Mulligan LaRossia, RN, NICHD: Linda L. Wright, MD, Elizabeth M. McClure, Med, Stephanie Wilson Archer, MA; Indiana University, University Hospital, Methodist Hospital, Riley Hospital for Children, and Wishard Health Services (U10 HD27856, M01 RR750): Brenda B. Poindexter, MD, MS, James A. Lemons, MD, Anna M. Dusick, MD, Carolyn Lytle, MD, MPH, Lon G. Bohnke, MS, Greg Eaken, PhD, Dianne E. Herron, RN, Lucy C. Miller, RN, BSN, CCRC, Heike M. Minnich, PsyD, HSP, Leslie Richard, RN, Leslie Dawn Wilson, BSN, CCRC, Faithe Hamer, BS, RTI International (U10 HD36790): W. Kenneth Poole, PhD, Dennis Wallace, PhD, Jamie E. Newman, PhD, MPH, Jeanette O'Donnell Aunman, BS, Margarett Cunningham, BS, Betty K. Hastings, Elizabeth M. McClure, Med, Carolyn M. Petrie Huitema, MS, Kristin M. Zaterka-Baxter, RN, BSN, Stanford University, California Pacific Medical Center, Dominican Hospital, El Camino Hospital, and Lucile Packard Children's Hospital (U10 HD27880, M01 RR70): David K. Stevenson, MD, Susan R. Hintz, MD, MS Epi, Maran M. Adams, MD, Charles E. Ahlfors, MD, M. Bethany Ball, BS, CCRC, Joan M. Baran, PhD, Barbara Bentley, PhD, Lori E. Bond, PhD, Ginger K. Brudos, PhD, Alexis S. Davis, MD, MS, Maria Elena DeAnda, PhD, Anne M. DeBattista, RN, RNP, Jan T. Epcaar, MA, Barry E. Fleisher, MD, Magdy Ismael, MD, MPH, Jean G. Kohn, MD, MPH, Carol G. Kuelper, PhD, Julie C. Lee-Anacjas, PhD, Melinda S. Proud, RCP, Renee P. Phl, PhD, Dharsi Sivakumar; MD, MRCP, Robert D. Stebbins, MD, Nicholas H. St. John, PhD, Tufts Medical Center, Floating Hospital for Children (U10 HD53119, M01 RR54): Ivan D. Frantz III, MD, Elisabeth C. McGowan, MD, Brenda L. MacKinnon, RN, Ellen Nylén, RN, BSN, Anne Furey, MPH, Cecelia Sibley, PT, MHA, Anna Brussa, MS, OTR/L; University of Alabama at Birmingham Health System and Children's Hospital of Alabama (U10 HD34216, M01 RR32): Namasiyam Ambalavanan, MD, Myriam Peralta-Carcelen, MD, MPH, Kathleen G. Nelson, MD, Kirstin J. Bailey, PhD, Fred J. Biasini, PhD, Stephanie A. Chopko, PhD, Monica V. Collins, RN, BSN MaEd, Shirley S. Cosby, RN, BSN, Mary Beth Moses, PT, MS, PCS, Vivien A. Phillips, RN, BSN, Julie Preskitt, MSOT, MPH, Richard V. Rector, PhD, Sally Whitley, MA, OTR-L, FAOTA, University of California, San Diego Medical Center and Sharp Mary Birch Hospital for Women and Newborns (U10 HD40461): Neil N. Finer, MD, Yvonne E. Vaucher, MD, MPH, Maynard R. Rasmussen MD, Paul R. Wozniak, MD, Kathy Arnell, RNC, Renee Bridge, RN, Clarence Demetrio, RN, Martha G. Fuller, RN, MSN, Donna Posin, OTR/L, MPA, Wade Rich, BSHS, RRT; University of Iowa Children's Hospital and Mercy Medical Center (U10 HD53109, M01 RR59): John A. Widness, MD, Tarah T. Colaizy, MD, Dan L. Ellsberg, MD, Karen J. Johnson, BSN, Diane L. Eastman, RN, CPNP, MA, Donia D. Campbell, RN; University of Miami, Holtz Children's Hospital (U10 HD21397, M01 RR16587): Charles R. Bauer, MD, Shahnaz Duara, MD, Ruth Everett-Thomas, RN, MSN, Amy Mur Worth, RN, MS, Mary Allison, RN, Alexis N. Diaz, BA, Elaine O. Mathews, RN, Kasey Hamlin-Smith, PhD, Lisa Jean-Gilles, BA, Maria Calejo, MS, Silvia M. Frade Eguaras, BA, Silvia Hiriart-Fajardo, MD, Yamilee C. Gideon, BA, Michelle Berkovits, PhD, Alexandra Stoerger, BA, Andrea Garcia, MA, Helena Pierre, BA; University of New Mexico Health Sciences Center (U10 HD27881, U10 HD53089, M01 RR997): Kristi L. Watterberg, MD, Lu-Ann Papile, MD, Robin K. Ohls, MD, Conra Backstrom Lacy, RN, Jean R. Lowe, PhD, Rebecca Montman, BSN; University of Rochester Medical Center; Golisano Children's Hospital (U10 HD40521, M01 RR44, NCRR UL1 024160): Dale L. Phelps, MD, Ronnie Guillot, MD, PhD, Gary J. Myers, MD, Linda J. Reubens, RN, CCRC, Erica Burnell, RN, Mary Rowan, RN, Cassandra A. Horihan, MS, Julie Babish Johnson, MSW, Diane Hust, MS, RN, CS, Rosemary L. Jensen, Emily Kushner, MA, Joan Merzbach, LMSW, Lauren Zwetsch, RN, MS, PNP, Kelly Yost, PhD; University of Tennessee Health Science Center (U10 HD21415): Sheldon B. Korones, MD,
REFERENCES


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ABBREVIATIONS
CI—confidence interval
ELBW—extremely low birth weight
GDB—Generic Database
I+—infants who received prophylactic indomethacin during the first 24 hours and any enteral feeding during the first 3 days after birth
I+E—infants who received prophylactic indomethacin during the first 24 hours and did not receive enteral feeding during the first 3 days after birth
I-E—infants who did not receive prophylactic indomethacin during the first 24 hours but did receive enteral feeding during the first 3 days after birth
I-E—infants who did not receive prophylactic indomethacin during the first 24 hours and did not receive enteral feeding during the first 3 days after birth
NDI—neurodevelopmental impairment
NEC—necrotizing enterocolitis
NRN—Neonatal Research Network
OR—odds ratio
PDA—patent ductus arteriosus
RR—relative risk
SIP—spontaneous intestinal perforation

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Address correspondence to Waldemar A. Carlo, MD, Division of Neonatology, 176F Suite 9380, Women and Infants Center, University of Alabama at Birmingham, 619 20th St South, Birmingham, AL 35233. E-mail: wcarlo@peds.uab.edu

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Prophylactic Indomethacin and Intestinal Perforation in Extremely Low Birth Weight Infants

Peralta-Carcelen and Waldemar A. Carlo

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