North West Coast
Strategic Clinical Networks

Document Title	Optimising the management of women at risk of spontaneous preterm delivery
Version	1.0
Finalised On	2nd March 2016
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Risk assessment

All maternity care providers should assess women for risks associated with an increased risk of spontaneous preterm birth (PTB)

These should as a minimum include:

- Previous LLETZ
- Previous cone biopsy
- Previous mid trimester loss after 16 weeks
- Previous PTB up to 37+0 completed weeks
- Previous PPROM up to 37+0 completed weeks

Management of women at risk of spontaneous PTB

- All women identified as at increased risk of PTB should be reviewed in the Consultant antenatal clinic before 16 weeks gestation and risks discussed of PTB
- Each woman should have an individualised management plan which should include cervical length scanning as a minimum between 16+0 and 28+0 weeks of pregnancy. Cervical length scanning should be undertaken and interpreted by appropriately trained personnel
- A choice of either prophylactic vaginal progesterone or prophylactic cervical cerclage should be offered to women:

    - With a history of spontaneous preterm birth or mid-trimester loss between 16+0 and 34+0 weeks of pregnancy **and**
    - A cervical length of less than 25 mm on a transvaginal ultrasound scan that has been carried out between 16+0 and 24+0 weeks of pregnancy
    - Discuss the benefits and risks of prophylactic progesterone and cervical cerclage with the woman and take her preferences into account.
- Offer prophylactic vaginal progesterone to women with **no history of spontaneous preterm birth or mid-trimester loss** in whom a transvaginal ultrasound scan has been carried out between 16+0 and 24+0 weeks of pregnancy that reveals a cervical length of less than 25 mm.
- Consider prophylactic cervical cerclage for women in whom a transvaginal ultrasound scan has been carried out between 16+0 and 24+0 weeks of pregnancy that reveals a cervical length of less than 25 mm and who have either:
    - had preterm prelabour rupture of membranes (P-PROM) in a previous pregnancy **or**
    - a history of cervical surgery

Management of women in threatened spontaneous preterm labour

Any woman with symptoms suggestive of preterm labour should be advised to attend the local Consultant Led Obstetric Unit as soon as possible for assessment

At presentation at the unit, a full history and examination should be undertaken and discussed with an experienced Obstetrician.

- If the clinical assessment suggests that the woman is in suspected preterm labour and she is 29+6 weeks pregnant or less, advise

treatment for preterm labour as detailed below in corticosteroid and tocolysis section

- If the clinical assessment suggests that the woman is in suspected preterm labour and she is 30+0 weeks pregnant or more, consider transvaginal ultrasound measurement of cervical length or a diagnostic test to determine likelihood of birth within 48 hours. Act on the results as follows:
    - If cervical length is more than 15 mm, explain to the woman that it is unlikely that she is in preterm labour and think about alternative diagnoses discuss with her the benefits and risks of going home compared with continued monitoring and treatment in hospital advise her that if she does decide to go home, she should return if symptoms suggestive of preterm labour persist or recur
    - If cervical length is 15 mm or less, view the woman as being in diagnosed preterm labour and offer treatment as described below

    - Consider fetal fibronectin testing or phosphorylated IGFBP-1 as a diagnostic test to determine likelihood of birth within 48 hours for women who are 30+0 weeks pregnant or more if transvaginal ultrasound measurement of cervical length is indicated but is not available or not appropriate.

Management of women in actual spontaneous preterm labour

If the history and examination indicate preterm labour:

- **Corticosteroids**
    - Between 23+0 and 23+6 weeks gestation discuss steroids with the woman on an individual basis
    - Consider steroids between 24+0 and 26+0 weeks gestation
    - Offer steroids between 26+0 and 33+6 weeks gestation who are in suspected, diagnosed or established preterm labour, are

having a planned preterm birth or have P-PROM.
- Consider for women between 34 +0 and 35 +6 weeks of pregnancy who are in suspected, diagnosed or established preterm labour, are having a planned preterm birth or have P-PROM.

- **Tocolysis**
  - Consider nifedipine for tocolysis for women between 24+0 and 25+6 weeks of pregnancy who have intact membranes and are in suspected preterm labour.
  - Offer nifedipine for tocolysis to women between 26+0 and 33+6 weeks of pregnancy who have intact membranes and are in suspected or diagnosed preterm labour.

    If nifedipine is contraindicated, offer oxytocin receptor antagonists for tocolysis

- **Magnesium Sulphate**

  - Offer intravenous magnesium sulphate for neuroprotection of the baby to women between 24+0 and 29+6 weeks of pregnancy who arein established preterm labour or having a planned preterm birth within 24 hours.
  - Consider intravenous magnesium sulphate for neuroprotection of the baby for women between 30+0 and 33+6 weeks of pregnancy who are in established preterm labour or having a planned preterm birth within 24 hours.

Consultant Obstetrician should be informed of all women in actual preterm labour

- In women with a history suggestive of P- PROM,if pooling of amniotic fluid is not observed, consider performing an insulin-like growth factor

binding protein-1 test or placental alpha-microglobulin-1 test of vaginal fluid.

- If the cervix is more than 4cm dilated then delivery is very likely.

- Consider 'rescue' cervical cerclage for women between 16+0 and 27+6 weeks of pregnancy with a dilated cervix and exposed, unruptured fetal membranes. Do not offer 'rescue' cervical cerclage to women with signs of infection, active vaginal bleeding or uterine contractions

In utero transfer

In utero transfer (IUT) should be considered if the Neonatal unit is unable to accept the baby either due to capacity or gestational age of the baby.

- Requests for IUT should be made through the Regional Cot Bureau
- The Consultant Obstetrician on call should be informed

No woman should undergo IUT unless she is in actual preterm labour based upon history, examination, ultrasound cervical length scan/ positive FFN or phosphorylated IGFBP-1

Corticosteroidsteroids and tocolytics should be started prior to transfer

- A regional IUT proforma should be completed for all IUT, faxed over to Cot Bureau and sent to the accepting unit along with photocopied maternal health records
- All IUT should be consultant to consultant referral
- The transferring trust should be informed via Labour Ward of the outcome of the admission – i.e discharge or delivery by the accepting trust

Audit

All units should audit on an annual basis:

- Preterm deliveries less than 37 weeks
- Outcomes of women identified as at risk for spontaneous preterm delivery
- In utero transfers

Support for women and their families

- Signposting to wider support including charities such as BLISS, local support groups, counsellors, financial support, breastfeeding peer support, free BLISS helpline (0500 618140)
- Opportunity to receive relevant literature: e.g. information leaflets, BLISS handbooks
- Give map or any other available information (postcode etc) on transfer unit if IUT
- Ask parents about choice of feeding baby prior to delivery, in line with UNICEF guideline, offer breastfeeding support information or signpost to breastfeeding peer support
- Offer a tour of neonatal unit