### Preconception Care
- Collect detailed history and physical
- Screen BMI (risk very low and high)
- Screen for PTB risk factors and counsel/refer/treat as appropriate
- Ask about tobacco use and provide augmented counseling and offer smoking cessation programs for those who screen positive.
- Screen and treat for substance use and exposure and/or mental health concerns
- Counsel related to family planning and birth spacing
- Screen and treat all genitourinary infections
- Screen for domestic violence
- Optimize treatment of chronic diseases
- Set expectations for prenatal care especially for patients with IDDM, HTN and other chronic conditions requiring special care during pregnancy

### Prenatal Care
- All pregnant women with risk for PTB are given information about the potential signs and symptoms (NIH)
- Women having a planned preterm birth are given information about the risks and potential outcomes (NIH).
- Screen all OB patients for tobacco use, if positive counsel on risks and offer smoking cessation programs
- With singleton gestation and a prior spontaneous singleton PTB should be offered progesterone supplementation starting at 16 weeks of gestation, regardless of transvaginal ultrasound cervical length, to reduce the risk of recurrent spontaneous preterm birth. (not recommended with twin or triplet gestation) (ACOG) IM 17 a-hydroxyprogesterone caporate (17-OHP)
- Vaginal progesterone is recommended to reduce the risk of PTB in asymptomatic women with a singleton gestation without a prior PTB with an incidentally identified very short cervical length less than or equal to 20 mm before or at 24 weeks of gestation. Vaginal progesterone 200mg suppository or 90 mg gel nightly
- Tests, such as fetal fibronectin screening, bacterial vaginosis testing, and home uterine activity monitoring, are not recommended as screening strategies. (ACOG)
- Consider cervical length screening in women without a prior PTB (ACOG level B) prior to 24 weeks
- Optimize monitoring and treatment of chronic conditions
- No elective inductions or deliveries should be scheduled prior to 39 weeks gestation
- High risk for preeclampsia one baby aspirin (80 mg) per day after 12 weeks gestation

### Postpartum Care
- Counsel related to family planning especially the importance of > 18 mo pregnancy interval and the need for highly effective contraception
- Counsel PTB recurrence risk
- Counsel interventions recommended before next pregnancy
- Provide highly effective contraception
- Screen and follow up for depression

### Management of PTL
**Level A recommendations**
- Single course of corticosteroids recommended pregnant women between 24-34 weeks’ gestation at risk for delivery within 7 days
- Mag sulfate reduces severity and risk of cerebral palsy in surviving infants if administered when birth is anticipated before 32 weeks
- First line tocolytic treatment with beta- adrenergic agonist therapy, calcium channel blockers, or NSAIDs for short term prolongation of pregnancy (up to 48 hours) to allow for administration of antenatal steroids
- Antibiotics should not be used to prolong gestation or improve neonatal outcomes in women with pre-term labor and intact membranes

**Level B recommendations**
- For women with ruptured membranes or multiple gestations who are at risk of delivery within 7 days, a single course of corticosteroids is recommended between 24 weeks and 34 weeks of gestation.
- A single course of corticosteroids may be considered starting at 23 weeks of gestation for pregnant women who are at risk of preterm delivery within 7 days, irrespective of membrane status.
- A single repeat course of antenatal corticosteroids should, therefore, be considered in women who are less than 34 weeks of gestation, who are at risk of preterm delivery within the next 7 days, and whose prior course of antenatal corticosteroids was administered more than 14 days previously. Rescue course corticosteroids could be provided as early as 7 days from the prior dose, if indicated by the clinical scenario.
- Bed rest and hydration have not been shown to be effective for the prevention of preterm birth and should not be routinely recommended.
- The positive predictive value of a positive fetal fibronectin test result or a short cervix alone is poor and should not be used exclusively to direct management in the setting of acute symptoms.

References: ACOG guidelines 2016, NIH NICE quality standards 2016, NYS DOH WNY Perinatal Collaborative reviewed and approved of these guidelines March 2017