Prevention of Preterm Birth (PTB)

Preconception Care

All patients:

- 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 are given information about the potential signs and symptoms of PTB (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
- Women 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, IM 17 a-hydroxyprogesterone caproate (17-OHP) weekly. (Not recommended with twin or triplet gestation)
- 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 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 prior to 24 weeks. (ACOG level B)
- Optimize monitoring and treatment of chronic conditions
- No elective inductions or deliveries should be scheduled prior to 39 weeks gestation
- Recommend one baby aspirin (80 mg) per day after 12 weeks gestation for women at high- risk for preeclampsia. Risk Factors include: Prior hx preeclampsia, multiple gestations, chronic HTN, Type 1 or 2 diabetes, renal disease, autoimmune disorders (SLE, +APA)

Postpartum Care

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

Management of Preterm Labor (PTL)

Level A Recommendations

- Single course of corticosteroids recommended for pregnant women between 24-34 weeks' gestation at risk for delivery within 7 days
- Magnesium sulfate recommended to reduce severity and risk of cerebral palsy in surviving infants less than 32 weeks gestation if administered when birth is anticipated
- 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 gestation between 24 weeks and 34 weeks of gestation who are at risk of delivery within 7 days, a single course of corticosteroids is recommended.
- 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 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, NYSDOH

WNY Perinatal Collaborative reviewed and approved of these guidelines March 2017