

ANMC WOMEN'S HEALTH SERVICE GUIDELINES FOR THE MANAGEMENT OF PRETERM LABOR

Goals:

Idiopathic preterm labor cannot be inhibited for prolonged periods of time. Therefore, the goals when treating this condition are to:

- Delay delivery so that corticosteroids can be administered.
- Allow safe transport of the gravida, if indicated, to a facility that can provide an appropriate level of neonatal care if the patient delivers preterm.
- Prolong pregnancy when there are underlying, self-limited causes of labor, such as pyelonephritis or abdominal surgery, which are unlikely to cause recurrent preterm labor.

Definitions:

Preterm Labor - regular uterine contraction after ≥ 20 0/7 weeks to ≤ 36 6/7 weeks GA, which occur regularly, leading to progressive cervical change.

Associations with preterm birth:

1. Preterm premature rupture of membranes (see below)
2. Chorioamnionitis
3. Fetal anomalies
4. History of prior preterm labor
5. Multiple gestation
6. Polyhydramnios
7. Intrauterine fetal demise
8. Cervical insufficiency
9. Uterine anomalies
10. Placenta previa or abruptio placentae
11. Retained IUD
12. Serious maternal disease (e.g., preeclampsia)
13. Cervical conization or L.E.E.P.
14. Idiopathic

Preterm birth due to:

- PROM 35% of the time
- Maternal fetal complications 35%
- Idiopathic preterm labor 30%

Risks of recurrent preterm birth

First Birth	Second Birth	Next Birth Preterm
term	-----	5%
preterm	-----	15%
term	preterm	24%
preterm	preterm	32%

Routine Antibiotics, e. g., not just for Beta Strep prophylaxis

A Cochrane review concluded that antibiotics CANNOT be recommended in the routine management of women in preterm labor with intact membranes. A subgroup of women who have subclinical intrauterine infection theoretically might benefit from treatment with antibiotics, but there is no means for identifying these women at this time. It is also possible that the infectious process may be too advanced by the time preterm labor is clinically apparent for treatment to be effective.

A subsequent RCT confirmed the meta-analysis described above and affirmed the recommendation against routine antibiotic administration to women in preterm labor without evidence of infection.

CONTRAINDICATIONS TO TOCOLYSIS — The general contraindications to labor inhibition are:

- Intrauterine fetal demise
- Lethal fetal anomaly
- Non-reassuring fetal assessment
- Severe intrauterine growth restriction
- Chorioamnionitis
- Maternal hemorrhage with hemodynamic instability
- Severe preeclampsia or eclampsia

Known or suspected fetal maturity is not necessarily a contraindication to tocolysis as there are non-pulmonary morbidities associated with preterm birth. For example, a 30-week fetus with a mature amniotic fluid test is still at risk for intraventricular hemorrhage, sepsis, hyperbilirubinemia, and other morbidities unrelated to hyaline membrane disease. These fetuses could potentially benefit from prolongation of pregnancy. Inhibition of preterm labor is less effective when cervical dilatation is advanced (greater than 3 cm). Tocolysis can also be considered in these cases, especially when the goal is to administer antenatal corticosteroids or safely transport the gravida to a tertiary care center.

Other Background

Betamimetics help to delay delivery for women transferred to tertiary care or completed a course of antenatal corticosteroids but are not recommended as a first line tocolytic or for long term therapy.

The evidence from this new review supports the continued use of a single course of antenatal corticosteroids to accelerate fetal lung maturation in women at risk of preterm birth. A single course of antenatal corticosteroids should be considered routine for preterm delivery with one rescue course < 33 6/7 wks if preterm delivery is expected within 7 days. (See ANMC Antenatal Corticosteroids for Fetal Benefit)

Numerous large clinical studies have evaluated the evidence regarding magnesium sulfate, neuroprotection, and preterm births. None of the individual studies found a benefit with regard to their primary outcome. However, the available evidence suggests that magnesium sulfate given before anticipated early preterm birth reduces the risk of cerebral palsy in surviving infants < 31 6/7. (See ANMC Magnesium Sulfate for Fetal Neuroprotection)

Management:

1. History of Preterm Labor with preterm delivery
 - a. preconceptual counseling to eliminate risk factors, e.g., stop tobacco, alcohol, drugs, space pregnancies, good nutrition, normalize hypertension, stabilize maternal medical conditions, anticipate need for increased pregnancy surveillance and prophylactic rest.
 - b. early pregnancy care
 - c. excellent dating by exam and early ultrasound
 - d. obtain cervical length 16-24 wks+
 - e. urine culture x1
 - f. preterm labor education by qualified personnel by $\geq 20\ 0/7$ to $\leq 23\ 6/7$ weeks GA.
 - g. intensive monitoring for signs and symptoms of recurrent preterm labor and/or asymptomatic cervical change
signs & symptoms:
 - *increased vaginal discharge
 - *blood tinged mucus
 - *low backache
 - *pelvic pressure
 - *menstrual - like cramps
 - *intestinal cramping, with or without diarrhea
 - *"not feeling right"
 - *precocious cervical dilations (1 cm or more)
 - j. If cervical changes, or transvaginal ultrasound cervical length <2.5 cm, or fibronectin fFN positive- remain in urban area for routine prenatal care

2) If local resources do not permit, consider counseling the patient to remain in urban area regardless of cervical findings. Time of patient remaining in urban area should be based on prior time of preterm birth.
 - k. See ANMC Progesterone for the Prevention of Recurrent Preterm Birth guideline
2. History of preterm labor with Term Delivery- Same as 1.
 3. History of preterm labor due to prior maternal or fetal Complications
 - a. Reassess risk of recurrence
 - if prior preterm birth associated with nonrecurring condition, i.e. twins, preterm birth risk probably same as "normal" singleton pregnancy.
 - b. Liberally consult OB-GYN to determine risk of recurrent preterm labor and management.

+ Cervical length screening will be performed by TVUS on asymptomatic pts from 16-24 wks with a hx of PTD $\leq 33\ 6/7$ wks according the Dept to Dept Agreement between Radiology and MFM/OB

Previous spontaneous preterm birth $< 29\ 6/7$ wks:

At initial prenatal visit, refer to MFM for consultation regarding when to start cervical length screening

Previous spontaneous preterm birth > 30 0/7 – < 33 6/7 wks:

Perform TVUS for cervical length at time of anatomy US (20-22 wks)

-If < 2.5 cm refer to MFM

-If \geq 2.5 - < 3.0 cm repeat in one week and refer to MFM if \leq 2.5 cm

-If \geq 3.0 no further follow-up needed

4. Current preterm labor

Step One

- a. Review pregnancy dating
- b. Obtain cervico-vaginal swab for fFN before you perform cervical exam
(a negative fFN has a 99% negative predictive value [NPV] for not delivering in the next 7-10 days, but a positive fFN only has a positive predictive value [PPV] of 13%).
- c. Obtain transvaginal cervical length (TVCL) for symptomatic pts \leq 33 6/7 wks to help with clinical triage. (Cervical length of limited clinical benefit \geq 34 0/7 wks)

-Cervical length > 3 cm: Low risk (< 5% risk of PTD in one wk)
-Cervical length 2- 3 cm: Low risk, but consider adding FFN
(< 5% risk of PTD in one wk if both neg)
-Cervical length < 2 cm: High risk (> 25% risk of PTD in one week)
- d. Obtain rectovaginal swab for group B strep (GBS)
(repeat screening for gonorrhea and chlamydia not necessary if negative earlier in pregnancy).

Step Two

- a. Rule out maternal fetal complications before initiating tocolytic Therapy (See Contraindications)
- b. obtain NST
- c. repeat U/S as needed to check fetal anatomy, size, amniotic fluid volume, and placentation(see Step One)
- d. monitor maternal status for infections, hypertensive disease, bleeding, etc.

Step Three

If GA < 33 6/7 weeks

-Initiate group B strep prophylaxis per GBS guideline

- a. Tocolyze (regimens below)
- b. Initiate neuroprotection (regimen below)
- c. Administer corticosteroids

A single course of corticosteroids is recommended for pregnant women between \geq 23 0/7 - \leq 33 6/7 wks if they are at risk of delivering within 7 days.

betamethasone 12 mg IM x2 doses 24 hrs apart,

or
dexamethasone 6 mg IM x 4 doses 12 hours apart

'Rescue' steroids ≥ 24 0/7 wks $50 \leq 33$ 6/7 wks and management of late preterm (≥ 34 0/7 - ≤ 36 6/7 wk) pregnancies (regimens below)

d. Liberally consult OB - GYN consultant re: management or transfer

Step Four

- Preterm labor education while hospitalized
- Outpatient management if medical adherence assured.
- Social Service, Mental Health, and Home Health Care consults may be appropriate.

Step Five

- If discharged, the patient should be seen in clinic on a weekly basis.
- Symptoms and adherence are re-assessed at each visit and cervical exam is considered at each encounter.
- Preterm labor recommendations are maintained until ≤ 33 6/7 weeks GA.
- Patients referred from outside an urban area remain in urban area until preterm labor is resolved.
- These patients should not transfer back to their Service Unit until their delivery could be safely managed by their local Level 1 Nursery, e. g., after 36 0/7 weeks. The patient should return to the Service Unit Hospital and not to their village until approved locally.
- Notify referring provider prior to patients return to Service Unit.

A. Tocolysis

< 31 6/7 wks: Initiate tocolysis with non-steroidal anti-inflammatory

Indomethacin

There are RCTs and Cochrane reviews which support the use of Indomethacin

Indomethacin 50 mg po initially, followed by 25 mg po q4h for a maximum of 48 hours. Re-evaluate with an OB/GYN after a maximum of 400 mg total.

or

Ketorolac

There is less data to support the use of ketorolac, but it has been effective in our setting.

Administered ketorolac 30 mg loading dose followed by 30 mg every 6 hours for a maximum of 48 hours intravenously or intramuscularly

Contraindications — Maternal contraindications to cyclooxygenase inhibitors include platelet dysfunction or bleeding disorder, hepatic dysfunction, gastrointestinal ulcerative disease, renal dysfunction, and asthma (in women with hypersensitivity to aspirin).

Ductal constriction appears to depend upon both gestational age and duration of exposure.

> 32 0/7 - < 33 6/7 wks, if BP > 90/60

Nifedipine: An optimal nifedipine dosing regimen for treatment of preterm labor has not been defined.

A common approach is to administer an initial loading dose of 20 mg orally, followed by a second dose of 20 mg orally in 90 minutes. If contractions persist, 20 mg can be given orally every 6 hours for 48 hours, with a maximum dose of 180 mg/day.

The half-life of nifedipine is approximately two to three hours and the duration of action of a single orally administered dose is up to six hours. Plasma concentrations peak in 30 to 60 minutes. Nifedipine is almost completely metabolized in the liver and excreted by the kidney.

Contraindications — This agent has been associated with hypotension and headache. Calcium channel blockers are contraindicated in women with known hypersensitivity to the drug and should be used with caution in women with left ventricular dysfunction or congestive heart failure. The concomitant use of a calcium-channel blocker and magnesium could theoretically act synergistically to suppress muscular contractility, which could result in respiratory paralysis, but despite extensive clinical use, this has rarely been encountered. Nifedipine may be used concomitantly with magnesium sulfate for neuroprotection (see below).

Triage therapy

Beta agonists

-For the management of acute preterm < 24 hours labor, terbutaline can also be administered subcutaneously by intermittent injection. The dose for intermittent injections is variable: 0.25 mg SQ and repeat q4h prn not to exceed 2 doses or until tocolysis is achieved. The drug should be withheld if the maternal heart rate is exceeding 120 beats/min.

Terbutaline is a good triage drug: if 1-2 doses over 4 hours abolish the contractions, it is unlikely that true preterm labor exists. A negative fFN and/or TVCL >2 cm should be able to confirm this impression.

-For anticipated > 24-hour therapy use other agents

Contraindications — Labor inhibition with a beta-adrenergic receptor agonist is relatively contraindicated among women with cardiac disease because of potent chronotropic effects. It can unmask undiagnosed CHD. Women with poorly controlled hyperthyroidism or diabetes mellitus should likewise not receive this class of labor inhibiting agents. Well-controlled diabetes mellitus is not a contraindication to beta-adrenergic receptor agonist therapy, as long as glucose and potassium concentrations are followed carefully and regulated. Beware of pulmonary edema.

Beta-adrenergic receptor agonists have important metabolic effects as well, including hypokalemia, hyperglycemia, and lipolysis. Glucose and potassium concentrations should be monitored during drug administration since hyperglycemia (140 to 200 mg/dL)

and hypokalemia occur in 20 to 50 percent and 40 to 60 percent of patients, respectively.

CAUTION:

It is reasonable to consider beta-adrenergic agonists as agents for treatment of preterm labor. However, beta-adrenergic agents should not be the first choice in women with cardiac disease, diabetes mellitus, or hyperthyroidism.

By comparison, indomethacin should be avoided in the setting of maternal platelet dysfunction or bleeding disorder, hepatic dysfunction, gastrointestinal ulcerative disease, renal dysfunction, or asthma (in women with hypersensitivity to aspirin). In these cases, consider other agents.

B. Neuroprotection

See

1.) ANMC Magnesium Sulfate for Fetal Neuroprotection Guideline for complete details

A. Indications

1. Women at $\geq 24\ 0/7^*$ - $\leq 31\ 6/7$ weeks with preterm labor (defined as regular at least every 5 minutes uterine contractions accompanied by cervical change, and/or positive fetal fibronectin (fFN), and/or transvaginal ultrasound cervical length <1.5 cm) at $\leq 33\ 6/7$ weeks gestation, with either a singleton or twin pregnancy, who are expected to deliver within the next 24 hours.

2. Women with preterm premature rupture of membranes (PPROM) (documented by usual clinical criteria of pooling and ferning, and confirmed if necessary, by oligohydramnios on ultrasound or a positive dye test), at or less than 32 weeks gestation, upon diagnosis and/ or in active labor.

B. Exclusions

1. Women with a short cervix on ultrasound not anticipated to deliver within 24 hrs.
2. Women with preterm contractions without cervical change, or women with a negative fFN.
3. Women who are being induced preterm for severe preeclampsia who would receive magnesium sulfate for a more prolonged period, and possibly at a different dose.
4. Women who have not delivered within 12 hours of admission for preterm labor or PPRM.
5. Women $\leq 24\ 6/7$ weeks: only give 4 gm bolus and 1 gm per hour*

Magnesium sulfate is usually administered as a 6 g intravenous load over 20 minutes, followed by a continuous infusion of 2 g/hour x 12 hrs. This therapy can be repeated if recurrent PTL that may deliver within the next 24 hrs. This therapy is to increase neuroprotection for the fetus, not for tocolysis.

-Group B strep prophylaxis per GBS guideline

Contraindications — Magnesium sulfate is contraindicated in women with myasthenia gravis. . It also should not be used in women with known myocardial compromise or cardiac conduction defects because of its anti-inotropic effects. Magnesium is eliminated by the kidneys, therefore women with impaired renal function may develop magnesium toxicity at the usual doses of administration. These women should receive the maintenance phase of treatment only if a patellar reflex is present (loss of reflexes being the first manifestation of symptomatic hypermagnesemia), respirations exceed 12 per minute, and the urine output exceeds 100 mL per four hours. Urine output and deep tendon reflexes should be closely monitored. Evaluation of serum magnesium concentration should be performed as needed.

Calcium gluconate (1 g intravenous slowly) may be administered to counteract magnesium toxicity.

'Rescue' Steroids ≥ 24 0/7 wks ≤ 33 6/7 wks

A single repeat course of antenatal corticosteroids should be considered in women whose prior course of corticosteroids was administered at 7 days previously and who remain at risk of preterm birth before 34 wks. However, regularly scheduled repeat courses or multiple courses (more than two) are not recommended.

Management of Late Preterm (≥ 34 0/7 wk ≤ 36 6/7 wks)

1. In women with a singleton pregnancy between 34 weeks 0 days -36 weeks 6 days of gestation who are at high risk for PTB within the next 7 days (but before 37 weeks of gestation), we recommend treatment with betamethasone (two doses of 12 mg IM twenty-four hours apart).
2. In women with preterm labor symptoms in the late preterm (LPT) period, please wait for evidence of preterm labor, such as a cervical dilatation of at least 3 cm or effacement of at least 75%, before treatment with betamethasone.
3. Late preterm antenatal corticosteroid administration should NOT be used in women diagnosed with chorioamnionitis.
4. Administration of late preterm antenatal corticosteroids should NOT be given if the pregnancy was already exposed to antenatal corticosteroids.
5. In women with LPT pregnancies receiving betamethasone, please avoid the use of tocolysis in an attempt to delay delivery to complete the steroid course since it is unclear if the benefits of betamethasone administration are outweighed by the risks of attempts to delay delivery.
6. In women with LPT pregnancies with a potential medical indication for delivery, betamethasone need not be given unless there is a definitive plan for LPT delivery.
7. These recommendations exclude patients with:

Pregestational diabetes, multifetal gestations, previous exposure to steroids during this pregnancy, or pregnancies with one major or two minor non-lethal fetal malformations. (see Appendix 1)

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10/6/15

8/14/13

5/2/13

2/7/11

3/2/02

10/26/98

7/31/97

10/11/95

10/1/94

1/15/88

6/1/80

Appendix 1

(See Table 1 and Table 2)

Table 1: Major Fetal Anomalies / Congenital Malformations

(Need one major anomaly for exclusion)

Pulmonary

Congenital diaphragmatic hernia (CDH)
Congenital cystic adenomatoid malformation
Pleural effusions
Chylothorax
Bronchogenic cyst
Bronchopulmonary sequestration

Cardiac

Anomalous pulmonary venous return
Tricuspid atresia
Mitral atresia
Double right ventricle
Epstein's malformation
Pulmonary atresia
Hypoplastic left heart syndrome
Transposition of great vessels
Tetralogy of Fallot
Double outlet right ventricle
Aortic stenosis
Aortic coarctation
Fetal arrhythmia (tachycardia, bradycardia, or supraventricular tachycardia)

Genito-urinary

Any genitor-urinary lesion accompanied by oligohydramnios at <24 wks

Bilateral renal agenesis

Cystic renal disease (polycystic or multicystic)

Obstructive uropathy

Horseshoe kidney

Megacystis microcolon

Cloacal abnormality

CNS

Anencephaly

Holoprosencephaly

Dandy-walker malformation or variant

Septo-optic dysplasia

Neural tube defect

Vein of Galen aneurysm

Skeletal

Acondrogenesis

Thanatophoric dysplasia

Osteogenesis imperfecta

Thoracic dysplasia

Hypophosphatemia

Short rib polydactyly

Any skeletal defect with suspected small thorax

Other

Any karyotype abnormality

Any suspected genetic syndrome

Cleft lip/palate

Micrognathia

Hydrops

Fetal anemia

Neck mass

Gastroschisis

Table 2: Minor Fetal Anomalies / Congenital Malformations

(Need two minor anomalies for exclusion)

Cardiac

ASD

VSD

Intracardiac echogenic focus

CNS

Choroid plexus cysts (unilateral or bilateral)

Mild ventriculomegaly (defined by a lateral ventricle measurement of <1.5cm)

Agensis of the corpus callosum
Arachnoid cyst

Genito-urinary

Pyelectasis
Hydronephrosis
Unilateral renal agenesis (normal AFI)
Pelvic kidney
Hypospadias

Skeletal

Achondroplasia (with normal thoracic circumference)
Clubbed foot (unilateral or bilateral)

Other

Echogenic bowel (Cystic fibrosis negative)
Polydactyly