Best Practice Guideline

I. Preterm Labor

II. Diagnosis and Screening
   a. Maternal vital signs, FHR/TOCO monitoring
   b. Review patient’s medical, obstetrical history, gestational age, pregnancy complications
   c. Speculum examination:
      i. Cervical dilation/effacement
      ii. Status of fetal membranes (intact or ruptured)
      iii. Presence and amount of uterine bleeding
      iv. Obtain fFN (decide to send to laboratory after complete evaluation)
      v. GBS culture if not done within previous 5 weeks
      vi. GC/Chlamydia for women at increased risk for these infections
   d. Ultrasound examination:
      i. Fetal presentation, amniotic fluid volume, fetal weight estimate
      ii. Cervical length via transvaginal ultrasound (consider in pregnancies < 34 weeks gestation)
   e. Digital examination:
      i. Cervical dilation and effacement (after excluding placenta previa and PPROM)
   f. Laboratory evaluation:
      i. UA and urine culture
      ii. Drug testing for patients at risk

III. Surveillance / Follow-up Interval
   a. Triage of patients with suspected preterm labor (<34 weeks gestation):
      i. Clinical diagnosis of preterm labor (contractions plus cervical dilation >2 cm or effacement >80%) → preterm labor
      ii. TV US: CL <2.0 cm → preterm labor likely
      iii. TV US: CL >3.0 cm → preterm labor unlikely, discharge home after appropriate observation
      iv. TV US: CL 2.0-3.0 cm and FFN + → preterm labor likely
      v. CL 2.0-3.0 cm and FFN
         1. if contractions cease → preterm labor unlikely, discharge home after appropriate observation
         2. if contractions persist → 24 hour observation
IV. Treatment Indications

a. Management (<34 weeks gestation) of acute preterm labor:
   i. A course of betamethasone
      1. Rescue dose if:
         a. <33 weeks,
         b. >2 weeks from initial course
         c. initial course at <28 weeks
   ii. Tocolytic drugs for up to 48 hours to delay delivery so that steroids can achieve maximum effect
      1. Choice of tocolytic:
         a. 24-32 weeks gestation: indomethacin, nifedipine
         b. 32-34 weeks gestation: nifedipine, terbutaline
         c. Injectable terbutaline should not be used in pregnant women for prevention or prolonged treatment (beyond 48 hrs) of preterm labor. Oral terbutaline should not be used for prevention or any treatment of preterm labor.
   iii. Antibiotics for GBS prophylaxis when appropriate
   iv. Antibiotics for UTI if diagnosed
   v. Magnesium sulfate for neuroprophylaxis
      1. pregnancies at 24-32 weeks gestation
      2. women at risk for imminent delivery

b. Management after inhibition of acute preterm labor
   i. Outpatient management for stable patients
   ii. Inpatient management based on risk factors (such as advanced cervical dilation, vaginal bleeding, nonreassuring fetal status, long travel time to a hospital)
   iii. No maintenance tocolysis

c. Progesterone supplementation to reduce the risk of spontaneous preterm birth
   i. Singleton pregnancy, prior spontaneous preterm birth
      1. hydroxyprogesterone caproate 250 mg IM weekly 16-36 weeks gestation
      2. cervical length surveillance
   ii. Singleton pregnancy, midtrimester (< 25 weeks) cervical shortening
      1. vaginal progesterone treatment

References:


Terbutaline: Label Change - Warnings Against Use for Treatment of Preterm Labor


