Designed by Oxford AHSN Maternity Network/ Patient Safety Academy Version Updated July 2023

Use of cervical scans and cerclage at <25 weeks to prevent spontaneous severe singleton preterm labour

Symptomatic:
No cerclage[1] if contracting

Please use QUIPP app if possible in conjunction with cervical length to determine steroids, IUT/ admission.
This remains valid >24 weeks

Asymptomatic:
Medium[2] risk for severe spontaneous preterm labour, OR
any[2,3]
TVS cervix[5] at ≤25+0

Asymptomatic:
High risk[2] for severe spontaneous preterm labour
TVS cervix[5] at ≤25+0

If <16w screen for BV[4] : Rx if positive

Start Cyclogest[5]

History indicated cerclage[6]
yes
no

TVS cervix[3] at >16+0, ≤25+0
1-4[2] weekly

≤ 15mm
>15mm, ≤25mm [7]
>25mm
0mm/ through os
≤25mm
>25mm

Start cyclogest [5] Consider repeat 1-2 w if <23w

No further action [2] Repeat as per existing plan

Chorioamnionitis?[8]
Yes
no/unsure 9

Consider amniocentesis[10]
Infection [11]
No infection [15]

Start cyclogest, consider cerclage [5,12]

Offer *rescue* Cerclage [13]

Deliver, with optimisation package [14]

Offer Cerclage

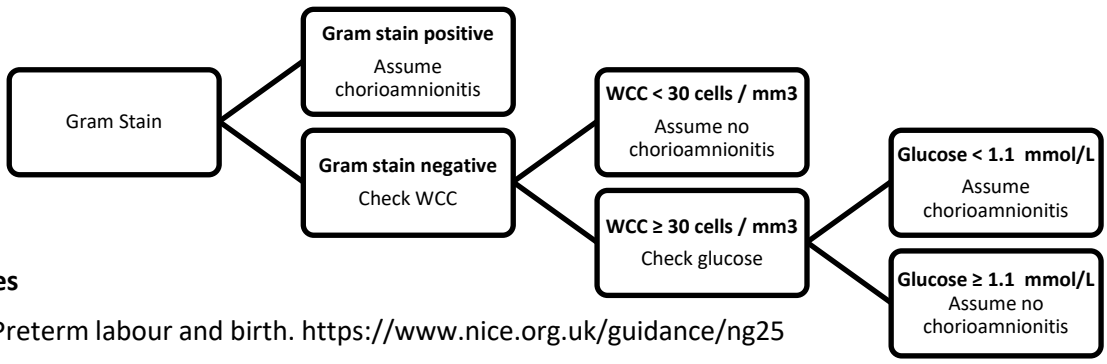
Elective[6] Cerclage

Please note:

- This is not meant to guide preterm labour clinic policy on when to do cervical scans, more what action to take if they are done. It briefly addresses threatened preterm labour for clarity.
- This does not cover women who have had previous failed non-rescue cerclage/ intensive surveillance, or who had extensive cervical surgery such as radical trachelectomy. Abdominal cerclage is commonly advised in these women.

Footnotes

1. Symptomatic of preterm birth: painful uterine contractions. Follow guideline on management of threatened preterm birth
2. High risk: previous spontaneous birth 16-31+6 weeks
   Medium risk: eg prev cervical surgery, >1 intrauterine procedure, uterine abnormalities etc . Follow local policy on frequency of screening. In multiple pregnancy: note NICE does not advise but evidence is emerging regarding benefits of treatment in highly selected women
   Low risk: no risk factors. Scans for low risk currently not nationally sanctioned but evidence of potential benefit: follow local guideline/ policy.
3. TVS cervix: vaginal ultrasound of cervical length (follow FMF steps). Do not perform as screening test in asymptomatic women > 25+0 weeks
4. Bacterial vaginosis
5. Cyclogest PV/PR. Start at 12 weeks or if cervical scan abnormal, dependent on local policy. NICE recommends latter. Usual dose 400mg PV/PR od. Continue to 34-6 weeks.
6. Elective cerclage is an alternative to serial cervical scans in high risk women. This should be according to individual circumstances, local guidelines and preference.
7. Note no evidence for cervical cerclage at this length in these women; there is evidence against cerclage for women with multiple pregnancy at this length
8. Chorioamnionitis: already present in up to 50%
9. Consider transfer to fetal medicine unit
10. Amniocentesis: for wbc, gram stain and glucose
11. Interpretation of amniocentesis (see below)
12. In these low risk women but with a very short cervix, an USS indicated cerclage should be considered in addition to progesterone.
13. Criteria for insertion of rescue cerclage:
    a. Appropriately skilled clinician and unit data on available outcomes AND
    b. Ability to appropriately monitor and treat if evidence of sepsis
14. Steroids, broad spectrum IVABs and magnesium: attempt transfer to Level 3 NNU unit if >22+6 , <27+0 weeks.



References

- NICE: Preterm labour and birth. https://www.nice.org.uk/guidance/ng25
- Romero et al. Vaginal progesterone decreases preterm birth ≤ 34 weeks of gestation in women with a singleton pregnancy and a short cervix: an updated meta-analysis including data from the OPPTIMUM study. Ultrasound Obstet Gynecol. 2016 Sep;48(3):308-17