

Prevention of preterm birth: screening proposal in accordance with SBL2/ Reducing Preterm Birth: Guidelines for Commissioners and Providers UK Preterm Clinical Network 2019
LI June 2019

For use in conjunction with 'Managing cervical length at <24 weeks to prevent spontaneous severe singleton preterm labour'

1. Prevention of Severe/ Extreme Preterm Birth

a. Referral issues

Unit antenatal guidelines will need to reflect risk factors as criteria for referral. It is the experience of most that referral to a consultant, who can then triage and allocate to a high risk or moderate risk pathway, works best. The alternative, less effective option, is direct referral for a cervical scan.

b. High risk pathway, comprising women with

Previous history of: 16-34 week birth
 SRM <34 weeks
 Radical trachelectomy
 Prev cervical cerclage

Refer to consultant run preterm labour clinic

As a minimum this should comprise a session with a consultant with an interest and expertise in preterm labour prevention, facilities for bacterial vaginosis (BV) and sexually transmitted infection (STI) testing, and for cervical length scanning. It is advised that the person performing the cervical length scans has passed the Fetal Medicine Foundation cervical scanning module.

(<https://fetalmedicine.org/fmf-certification/certificates-of-competence/cervical-assessment-1>)

In high risk women the following are appropriate

Review after nuchal/ dating scan at 11-14 weeks

Usual booking issues, particularly consider criteria for aspirin

Vaginal examination to ensure cervix anatomically normal

Decision as to whether 1) elective cerclage OR 2) serial ultrasound (TVS) and cerclage if shortening found is appropriate

Decision as to whether an abdominal cerclage is appropriate, eg if previous failed trans vaginal cerclage, or minimal external cervix present. Refer to appropriate clinician (eg Oxford FMU)

Consideration of prophylactic progesterone supplementation (cyclogest 400mg od, PV/PR)

Review at 2-3 weekly intervals until 26 weeks, incl TVS cervix if no cerclage

USS indicated cerclage if cervix <25mm

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c. Moderate risk pathway, comprising women with

Previous history of: LLETZ/ cone

Known abnormal uterus

10 cm Caesarean section

? consider multiple pregnancy

Arrange single TVS cervix around 20 weeks

If <25mm progesterone supplementation (cyclogest 400mg od, PV/PR). There is no clear benefit to cerclage in women with a cervical length of 11-24mm

Repeat at 2 weeks if scan <18 weeks, or if 10-15mm long

If <11mm consider also USS indicated cerclage

2. Prevention of moderate preterm birth

A reduction in birth at 34-37 weeks will also contribute to an overall reduction in preterm birth and help meet the national target of 6%.

This is particularly pertinent to the following women: those with reduced fetal movements (RFMs) and normal fetal surveillance, those whose babies are SGA but with normal fetal Doppler indices, and those with cholestasis with bile acid levels <100. In general such women should not be delivered prior to 37 weeks.

Areas of most relevance are:

See RFM guidelines

See cholestasis guidelines

See SGA/ IUGR guidelines