Antenatal care where birth imminent or indicated at less than 25 weeks+6 days

Inform the family that initiation of antenatal interventions does not oblige nor necessarily equate to a final decision for life sustaining interventions after birth - especially at extremely preterm or uncertain gestations.

Contact Level 6 service early in the decision making process

Decision making
- Advocate a family centred approach
- Consider ethical principles
- Involve multidisciplinary healthcare team
- Discussions are led by an experienced practitioner
- Coordinate and plan care at the earliest opportunity
- Review plans regularly
- Document decisions clearly

Counsel parents
- Consider individual circumstances
- Review case history and results
- Consider cultural needs
- Convey information in a manner that facilitates understanding
- Provide a compassionate but realistic assessment of the outlook
- Discuss prognosis, resuscitation and expectations for care
- Discuss quality of life

Consider outcome factors
- Gestational age +/- PAGE
- Estimated fetal weight
- Sex
- Plurality
- Congenital anomaly
- Antenatal pathology
- Place and mode of birth
- Plans regarding resuscitation

Contact RSQ to co-ordinate transfer (phone 1300 799 127)
Consult with higher level service as required
Aim for in-utero transfer unless transfer puts the mother’s life at risk
Recommend if preterm birth likely and life sustaining interventions planned or may be a possibility
Not indicated if palliative care planned
Consider context of care (considerably better prognosis if neonate born at centres with expertise)
If birth occurs, contact NeoRESQ for advice re stabilisation

Consider individual risk vs benefit of delaying birth:
- To allow administration of corticosteroids
- To achieve in-utero transfer
- Consider contraindications (e.g. placental abruption, maternal infection)

Refer to QCG: Preterm labour and birth

Corticosteroids are associated with reduction in rates of neonatal death, respiratory distress syndrome and IVH
Recommend from 22+0 weeks:
- If high risk of preterm birth
- Prior to in-utero transfer
- If life sustaining interventions are planned, uncertain or appropriate counselling is delayed
- 48 hours prior to birth (if possible)

Little evidence for interpretation of CTG before 28+0 weeks
Take fetal physiology into account when interpreting CTG at extremely preterm gestations
CTG not recommended before 24+0 weeks
Limited usefulness between 24+0 and 28+0 weeks depending on individual circumstances/clinician expertise

Magnesium sulfate given shortly before birth reduces the risk of cerebral palsy and protects gross motor function in infants born preterm
Recommended before 30+0 weeks where birth is imminent and life sustaining interventions are planned or may be a possibility
Refer to QCG: Preterm labour and birth

The evidence regarding CS for fetal indications at extremely preterm gestations is inconclusive and conflicting
Consider specific circumstances (e.g. gestation, plurality, presentation, obstetric history, future pregnancy, parental wishes)
Consensus recommendation: CS for fetal indications alone:
- Is not recommended before 24+0 weeks
- Is not usually recommended between 24+0 and 24+6 weeks
- May be recommended at or after 25+0 weeks depending on individual circumstances

Refer to Flowchart Resuscitation of extremely preterm baby