Assessment and management of preterm labour

Review History
- Medical, surgical, obstetric, social

Assess for signs and symptoms
- Pelvic pressure
- Lower abdominal cramping
- Lower back pain
- Vaginal loss – mucous, blood, fluid
- Regular uterine activity

Physical examination
- Vital signs
- Abdominal palpation
- Fetal surveillance – FHR, CTG
- Sterile speculum exam
  - Identify if ROM
  - Visualise cervix/membranes
  - High vaginal swab
  - Test for IFN
- Low vaginal/anorectal GBS swab
- Cervical dilatation
  - Sterile digital vaginal exam
  - unless ROM, placenta praevia
- Ultrasound – if available
  - Fetal growth and wellbeing

Laboratory
- High vaginal swabs for MC&S
- One swab (low vaginal + anal) for GBS
- Midstream urine for MC&S

Consider admission if:
- IFN > 50 ng/mL or
- Cervical dilatation or
- Cervical change over 2–4 hours or
- ROM or
- Contractions regular & painful or
- Further observation or investigation indicated or
- Other maternal or fetal concerns

In-utero transfer
- Aim for in-utero transfer wherever possible
- If gestation 23–28 weeks, accept a high level of risk for birth en-route (unless it puts mother’s life at risk)
- Coordinate transfer via RSQ phone: 1300 799 127

Antenatal corticosteroids (< 35+0 weeks)
- Recommend course of Betamethasone (2 doses)
  - 11.4 mg IM then 2nd dose in 24 hours
  - Consider 2nd dose at 12 hours if PTB likely within 24 hours
- If risk of PTB remains ongoing in 7 days, repeat dose

Tocolysis
- Nifedipine 20 mg oral
- If contractions persist after 30 minutes repeat Nifedipine 20 mg oral
- If contractions persist after further 30 minutes repeat Nifedipine 20 mg oral
- Maintenance therapy 20 mg every 6 hours for 48 hours

Discuss with Obstetrician/Paediatrician
- If contraindications exist
- If other options required (Indomethacin, Salbutamol)

Antibiotics:
- If established labour (or imminent risk of PTB) give intrapartum GBS prophylaxis regardless of GBS status or membrane status
- If chorioamnionitis (membranes intact or ruptured)
  - Amoxicillin (or Amoxycillin) 2 g IV initial dose, then 1 g IV every 6 hours
  - Gentamicin 5 mg/kg IV daily
  - Metronidazole 500 mg IV every 12 hours
- If Penicillin hypersensitivity and chorioamnionitis:
  - Lincomycin OR Clindamycin 600 mg IV every 8 hours and
  - Gentamicin 5 mg/kg IV daily and
  - Metronidazole 500 mg IV every 12 hours
- If labour does not ensue (and no evidence of chorioamnionitis) and membranes intact then cease antibiotics
- If PPROM, refer to Queensland Clinical Guideline: EOGBSD for regimen

Magnesium Sulfate
- Gestational age 24–30 weeks
- Labour established or birth imminent
  - Loading dose: 4 g IV bolus over 20 minutes
  - Maintenance dose: 1 g/hour for 24 hours or until birth – whichever occurs first

Prepare for birth
- Recommend vaginal birth unless there are specific contraindications to vaginal birth or maternal conditions necessitating caesarean section

Management after threatened preterm labour
- Plan care according to clinical circumstances
  - Maternal and fetal assessments
  - Transfer back to referring hospital where feasible
  - Discharge if usual criteria met
  - Inform the woman, GP and usual care provider about recommendations for future care

Consider as clinically appropriate

Discharge
- Provide information re: signs and symptoms and returning for care
- Arrange follow-up as indicated

Queensland Clinical Guidelines: Preterm labour and birth F14.6-1-V8-R19

CS: caesarean section, EOGBSD: early onset Group B Streptococcal disease, FBC: full blood count, GBS: Group B Streptococcus, IAP: intrapartum antibiotic prophylaxis, IV: intravenous, ROM: rupture of membranes, T: temperature, ≥: greater than or equal to