Preterm labour and birth: Appendix 2 Amended recommendation wording (change to intent) without an evidence review (June 2022 update)

Recommendation in [2015] guideline	Recommendation in current guideline	Reason for change
Not applicable.	Care of women at risk of preterm labour.	A new heading has been added into the guideline to differentiate the sections better.
1.2.1 Offer a choice of prophylactic vaginal progesterone or prophylactic cervical cerclage to women who have both: • a history of spontaneous preterm birth (up to 34+0 weeks of pregnancy) or mid-trimester loss (from 16+0 weeks of pregnancy onwards) and • results from a transvaginal ultrasound scan carried out between 16+0 and 24+0 weeks of pregnancy that show a cervical length of 25 mm or less. Discuss the risks and benefits of both options with the woman, and make a shared decision on which treatment is most suitable. In August 2019, this was an off-label use of vaginal progesterone. See NICE's information on prescribing medicines. **[2019]** 1.2.2 Consider prophylactic vaginal progesterone for women who have either: • a history of spontaneous preterm birth (up to 34+0 weeks of pregnancy) or mid-trimester loss (from 16+0 weeks of pregnancy onwards) or • results from a transvaginal ultrasound scan carried out between	1.2.1 Offer a choice of prophylactic vaginal progesterone or prophylactic cervical cerclage to women who have both: • a history of spontaneous preterm birth (up to 34+0 weeks of pregnancy) or loss (from 16+0 weeks of pregnancy onwards), **and** • results from a transvaginal ultrasound scan carried out between 16+0 and 24+0 weeks of pregnancy that show a cervical length of 25 mm or less. Discuss the risks and benefits of both options with the woman, and make a shared decision on which treatment is most suitable. In August 2019, this was an off-label use of vaginal progesterone. See NICE's information on prescribing medicines. **[2019, amended 2022]** 1.2.2 Consider prophylactic vaginal progesterone for women who have either: • a history of spontaneous preterm birth (up to 34+0 weeks of pregnancy) or loss (from 16+0 weeks of pregnancy onwards), **or** • results from a transvaginal ultrasound scan carried out between 16+0 and 24+0 weeks of	The word 'mid-trimester' has been removed from both these recommendations as the time frame suggested (from 16 weeks onwards) does not match with the accepted definition of mid-trimester which starts at 13 weeks.

16+0 and 24+0 weeks of pregnancy that show a cervical length of 25 mm or less. In August 2019, this was an off-label use of vaginal progesterone. See NICE's information on prescribing medicines. **[2019]**	pregnancy that show a cervical length of 25 mm or less. In August 2019, this was an off-label use of vaginal progesterone. See NICE's information on prescribing medicines. **[2019, amended 2022]**	
1.2.5 If prophylactic cervical cerclage is used, ensure that a plan is in place for removal of the suture. **[2019]**	1.2.5 If prophylactic cervical cerclage is used, ensure a plan is made and documented for removal of the suture. **[2019, amended 2022]**	The wording has been clarified to state that a plan should be made and recorded.
1.3.3 If the results of the insulin-like growth factor binding protein-1 or placental alpha-microglobulin-1 test are negative and no amniotic fluid is observed: • do not offer antenatal prophylactic antibiotics • explain to the woman that it is unlikely that she has P-PROM, but that she should return if she has any further symptoms suggestive of P-PROM or preterm labour. **[2015]**	1.3.3 If the results of the insulin-like growth factor binding protein-1 or placental alpha-microglobulin-1 test are negative and no amniotic fluid is observed: • do not offer antenatal prophylactic antibiotics • explain to the woman that it is unlikely she has P-PROM, but that she should return for reassessment if there are any further symptoms suggestive of P-PROM or preterm labour. **[2015, amended 2022]**	It has been clarified that the return is for a reassessment.
1.4.1 Offer women with P-PROM oral erythromycin 250 mg 4 times a day for a maximum of 10 days or until the woman is in established labour (whichever is sooner). **[2015]**	1.4.1 As prophylaxis for intrauterine infection, offer women with P-PROM oral erythromycin 250 mg 4 times a day for a maximum of 10 days or until the woman is in established labour (whichever is sooner). **[2015, amended 2022]**	The rationale for offering the antibiotics has been included, in line with other recommendations in this section.
1.6 Rescue cervical cerclage.	1.6 Emergency cervical cerclage.	The use of the term 'rescue' has been amended to 'emergency' in line with the terminology used in current clinical practice, in this heading and in the subsequent recommendations and recommendations for

		research in the guideline.
Not applicable.	Care of women with suspected or established preterm labour.	A new heading has been added into the guideline to differentiate the sections better.
1.8.1 Take the following factors into account when making a decision about whether to start tocolysis: • whether the woman is in suspected or diagnosed preterm labour • other clinical features (for example, bleeding or infection) that may suggest that stopping labour is contraindicated • gestational age at presentation • likely benefit of maternal corticosteroids (see section 1.9) • availability of neonatal care (need for transfer to another unit) • the preference of the woman. **[2015]**	1.8.1 Take the following factors into account when making a decision about whether to start tocolysis: • whether the woman is in suspected or diagnosed preterm labour • other clinical features (for example, bleeding or infection) that may suggest that stopping labour is contraindicated • gestational age at presentation • likely benefit of maternal corticosteroids (see the section on maternal corticosteroids) • availability of an appropriate level of neonatal care (if there is need for transfer to another unit). See also NHS England's guidance on saving babies' lives care bundle version 2 (recommendation 5.9). • the preference of the woman. **[2015, amended 2022]**	The fifth bullet point has been amended to clarify that it is the availability of the appropriate level of neonatal care that should be considered, if there is a need to transfer to another unit, and a link to the NHS England care bundle which references this has been included.
1.9.1 For women between 23+0 and 23+6 weeks of pregnancy who are in suspected or established preterm labour, are having a planned preterm birth or have P-PROM (see section 1.3), discuss with the woman (and her family members or carers as appropriate) the use of maternal corticosteroids in the context of her individual circumstances. **[2015]**	1.9.1 For women between 22+0 and 23+6 weeks of pregnancy who are in suspected or established preterm labour, are having a planned preterm birth or have P-PROM (see the section on diagnosing P-PROM), discuss with the woman (and her family members or carers, as appropriate) and the multidisciplinary team the use of maternal corticosteroids in the context	The lower limit for discussions about maternal corticosteroids has been changed from 23+0 to 22+0 weeks to reflect the improved viability of babies born at 22 weeks. The multidisciplinary team has also been added as a party to be included in these discussions.

	of her individual circumstances. **[2015, amended 2022]**	
1.9.4 When offering or considering maternal corticosteroids, discuss with the woman (and her family members or carers as appropriate): • how corticosteroids may help • the potential risks associated with them. **[2015]**	1.9.6 When offering or considering maternal corticosteroids, discuss the benefits and risks with the woman (and include her family members or carers, as appropriate). **[2015, amended 2022]**	The wording has been simplified to 'benefits and risks'.
1.10.6 If a woman has or develops oliguria or other signs of renal failure: • monitor more frequently for magnesium toxicity • think about reducing the dose of magnesium sulfate. **[2015]**	1.10.6 If a woman has or develops oliguria or other evidence of renal failure: • monitor more frequently for magnesium toxicity • reduce or stop the dose of magnesium sulfate. **[2015, amended 2022]**	The action to be taken has been clarified - there is a risk of hypermagnesaemia, which in turn could lead to cardiac conduction defects, neuromuscular effects and muscle weakness. The committee therefore agreed that the wording 'think about' was not strong enough and the dose of magnesium should be reduced or stopped.
1.13.2 Explain to women in suspected, diagnosed or established preterm labour and women with P-PROM about the benefits and risks of caesarean section that are specific to gestational age. In particular, highlight the difficulties associated with performing a caesarean section for a preterm birth, especially the increased likelihood of a vertical uterine incision and the implications of this for future pregnancies. **[2015]**	1.13.2 Explain to women in suspected, diagnosed or established preterm labour and women with P-PROM about the benefits and risks of caesarean birth that are specific to gestational age. In particular, highlight the difficulties associated with performing a caesarean birth for a preterm birth, especially the increased likelihood of a vertical uterine (classical) incision and the implications of this for future pregnancies. **[2015, amended 2022]**	The type of incision has been clarified as this is also known as a classical incision.
1.14.2 Wait at least 30 seconds, but no longer than 3 minutes, before clamping the cord of preterm babies if	1.14.1 Wait at least 60 seconds before clamping the cord of preterm babies unless there are specific	The time to clamping has been extended to at least 60 seconds in line with

the mother and baby are stable. **[2015]**	maternal or fetal conditions that need earlier clamping. **[2015, amended 2022]**	current practice, and to reflect the knowledge of the committee that delayed cord clamping had benefits in preterm birth.

ISBN: 978-1-4731-1529-3