ECU MFM Division Consensus

Preterm labor: acute September 9, 2009

Definition: Uterine contractions resulting in significant cervical change before 37w0d gestation.

Treatment for PTL is for those at <34w0d.

Tocolytic Therapy

1. Tocolytic therapy should be initiated in those patients at <34w0d gestation who are at significant risk of delivery within 7 days.

   Contraindications: Lethal fetal anomalies, intrauterine infection

   Relative contraindications: IUGR, non-reassuring antenatal testing (NST/BPP), oligohydramnios, pulmonary edema

2. Tocolytic therapy is to prolong pregnancy by 48 hours to obtain fetal benefits from antenatal corticosteroids.

3. Maintenance tocolyic use is discouraged and should be reserved for those with significant symptomatic contractions which result in multiple unscheduled encounters because of preterm contractions.

4. Beta-methasone (12 mg IM q 24 hours for 2 total doses) should be initiated between 23.0 and 33w6d if there is significant risk of delivery within 7 days. Serial steroids are not indicated. A rescue course of steroids should be given if first course of steroids was >21 days completed. Tocolytics may be reused to obtain this potential benefit of rescue doses.

5. Drug of choice for tocolysis (in order)

   i. Procardia 10-20 mg PO q 6 hours

   ii. Indocin 100 mg then 25 mg PO q 6 hours

      1. -Drug of choice if polyhydramnios is present, caution with oligohydramnios

      2. -If used for >72 hours, evaluate ductus arteriosus Doppler flow pattern.

   iii. Magnesium sulfate 4 gm load over 20 minutes then 2 grams / hour

6. Magnesium for cerebral palsy prevention

   i. Administer for anticipated delivery within 12 hours

   ii. Gestational age for administration: 23 weeks 0 days to 30 weeks 0 days

iii. Loading dose 4 grams/hour then 1-2 grams per hour

iv. Ideal duration of exposure is 2 hours

v. Stop administration of MgSO4 is risk of imminent delivery is resolved

vi. Re-administer if threat of imminent delivery recurs. If greater than 12 hours since previously on MgSO4 restart with bolus

vii. Maternal serum Mg levels are not routinely indicated.

7. Bed rest: There is no evidence that strict bed rest is efficacious except in higher order gestations to increase birth weight. Patients should be restricted to light activities and pelvic rest.

8. Progesterone is not indicated for acute / chronic preterm labor.

9. Fetal testing is not indicated in patients with isolated preterm labor. For those hospitalized, weekly NST and daily kick counts will suffice for fetal testing.

10. All preterm births will receive GBS prophylaxis at delivery unless there is a recent negative culture.