1.5 Identifying infection in women with P-PROM

1.5.1 Use a combination of clinical assessment and tests (C-reactive protein, white blood cell count and measurement of fetal heart rate using cardiotocography) to diagnose intrauterine infection in women with P-PROM. **[2015]**

1.5.2 Do not use any one of the following in isolation to confirm or exclude intrauterine infection in women with P-PROM:

- a single test of C-reactive protein
- white blood cell count
- measurement of fetal heart rate using cardiotocography. **[2015]**

1.5.3 If the results of the clinical assessment or any of the tests are not consistent with each other, continue to observe the woman and consider repeating the tests. **[2015]**

1.6 Emergency cervical cerclage

1.6.1 Do not offer emergency cervical cerclage to women with:

- signs of infection, **or**
- active vaginal bleeding, **or**
- uterine contractions. **[2015, amended 2022]**

1.6.2 Consider emergency cervical cerclage for women between 16+0 and 27+6 weeks of pregnancy with a dilated cervix and exposed, unruptured fetal membranes. Also:

- take into account gestational age (being aware that the benefits are likely to be greater for earlier gestations) and the extent of cervical dilatation
- discuss with a consultant obstetrician and consultant paediatrician. **[2015, amended 2022]**

1.6.3 If emergency cervical cerclage is being considered, explain to the woman (and their family members or carers, as appropriate):

- about the risks of the procedure
- that it aims to delay the birth, and so increase the likelihood of the baby surviving and of reducing serious neonatal morbidity **[2015, amended 2022]**

1.6.4 If emergency cervical cerclage is used, ensure that a plan is made and documented for removal of the suture. **[2019, amended 2022]**

For a short explanation of why the committee made the 2019 recommendation and how it might affect practice, see the rationale and impact section on emergency cervical cerclage.

Care of women with suspected or established preterm labour

1.7 Diagnosing preterm labour for women with intact membranes

1.7.1 Explain to women reporting symptoms of preterm labour who have intact membranes (and their family members or carers, as appropriate):

- about the clinical assessment and diagnostic tests that are available
- how the clinical assessment and diagnostic tests are carried out
- what the benefits, risks and possible consequences of the clinical assessment and diagnostic tests are, including the consequences of false-positive and false-negative test results and taking into account gestational age. **[2015]**

1.7.2 Offer a clinical assessment to women reporting symptoms of preterm labour who have intact membranes. This should include:

- clinical history taking
- the observations described for the initial assessment of labour in NICE's guideline on intrapartum care
- a speculum examination (followed by a digital vaginal examination if the extent of cervical dilatation cannot be assessed; be aware that if a swab for fetal fibronectin testing is anticipated [see recommendation 1.7.5] the swab should be taken before any digital vaginal examination). **[2015]**

1.7.3 If the clinical assessment suggests that the woman is in suspected preterm labour and she is 29+6 weeks pregnant or less, advise treatment for preterm labour as described in the sections on tocolysis and maternal corticosteroids. **[2015]**

1.7.4 If the clinical assessment suggests that the woman is in suspected preterm labour and she is 30+0 weeks pregnant or more, consider transvaginal ultrasound measurement of cervical length as a diagnostic test to determine likelihood of birth within 48 hours. Act on the results as follows:

- if cervical length is more than 15 mm, explain to the woman that it is unlikely to be preterm labour and:
  - think about alternative diagnoses
  - discuss with her the benefits and risks of going home compared with continued monitoring and treatment in hospital
  - advise her that if she does decide to go home, she should return if symptoms suggestive of preterm labour persist or recur
- if cervical length is 15 mm or less, view the woman as being in diagnosed preterm labour and offer treatment as described in the sections on tocolysis and maternal corticosteroids. **[2015]**

1.7.5 Consider fetal fibronectin testing as a diagnostic test to determine likelihood of birth within 48 hours for women who are 30+0 weeks pregnant or more if transvaginal ultrasound measurement of cervical length is indicated, but is not available or not acceptable. Act on the results as follows:

- if fetal fibronectin testing is negative (concentration 50 ng/ml or less), explain to the woman that it is unlikely she is in preterm labour and:
  - think about alternative diagnoses
  - discuss with her the benefits and risks of going home compared with continued monitoring and treatment in hospital
  - advise her that if she decides to go home, she should return if symptoms suggestive of preterm labour persist or recur
- if fetal fibronectin testing is positive (concentration more than 50 ng/ml), view the woman as being in diagnosed preterm labour and offer treatment as described in the sections on tocolysis and maternal corticosteroids. **[2015]**

1.7.6 If a woman in suspected preterm labour who is 30+0 weeks pregnant or more does not have transvaginal ultrasound measurement of cervical length or fetal fibronectin testing to exclude preterm labour, offer treatment consistent with her being in diagnosed preterm labour (see the sections on tocolysis and maternal corticosteroids). **[2015]**

1.7.7 Do not use transvaginal ultrasound measurement of cervical length and fetal fibronectin testing in combination to diagnose preterm labour. **[2015]**

1.7.8 Ultrasound scans should be performed by healthcare professionals with training in, and experience of, transvaginal ultrasound measurement of cervical length. **[2015]**

1.7.9 For guidance on the use of other biomarker tests used for the diagnosis of preterm labour, see NICE's diagnostics guidance on biomarker tests to help diagnose preterm labour in women with intact membranes. **[2019]**

1.8 Tocolysis

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]**

1.8.2 Consider nifedipine for tocolysis for women between 24+0 and 25+6 weeks of pregnancy who have intact membranes and are in suspected preterm labour.

In November 2015, this was an off-label use of nifedipine. See NICE's information on prescribing medicines. **[2015]**

1.8.3 Offer nifedipine for tocolysis to women between 26+0 and 33+6 weeks of pregnancy who have intact membranes and are in suspected or diagnosed preterm labour.

In November 2015, this was an off-label use of nifedipine. See NICE's information on prescribing medicines. **[2015]**

1.8.4 If nifedipine is contraindicated, offer oxytocin receptor antagonists for tocolysis. **[2015]**

1.8.5 Do not offer betamimetics for tocolysis. **[2015]**

1.9 Maternal corticosteroids

In June 2022 this was an off-label use of betamethasone and dexamethasone. See NICE's information on prescribing medicines.