Recommendations

People have the right to be involved in discussions and make informed decisions about their care, as described in NICE's information on making decisions about your care.

Making decisions using NICE guidelines explains how we use words to show the strength (or certainty) of our recommendations, and has information about prescribing medicines (including off-label use), professional guidelines, standards and laws (including on consent and mental capacity), and safeguarding.

1.1 Information and support

1.1.1 When giving information and support to women at increased risk of preterm labour, or with suspected, diagnosed or established preterm labour, or having a planned preterm birth (and their family members or carers as appropriate):

- ensure this is given as early as possible, taking into account the likelihood of preterm birth and the status of labour
- follow the principles in NICE's guideline on patient experience in adult NHS services
- bear in mind that the woman (and their family members or carers) may be particularly anxious
- give both oral and written information
- describe the symptoms and signs of preterm labour
- explain about the care that may be offered. **[2015]**

1.1.2 For women who are having a planned preterm birth or are offered treatment for preterm labour in line with the sections on tocolysis, maternal corticosteroids and magnesium sulfate for neuroprotection (and their family members or carers as appropriate), provide information and support that includes:

- information about the likelihood of the baby surviving and other outcomes (including long-term outcomes) and risks for the baby, giving values as natural frequencies (for example, 1 in 100)
- explanation of the neonatal care of preterm babies, including location of care
- explanation of the immediate problems that can arise when a baby is born preterm
- explanation of the possible long-term consequences of prematurity for the baby (how premature babies grow and develop)
- ongoing opportunities to talk about and state their wishes about resuscitation of the baby
- an opportunity to tour the neonatal unit
- an opportunity to speak to a neonatologist or paediatrician. **[2015]**

1.1.3 Be aware that, according to the 2021 Mothers and babies: reducing risk through audits and confidential enquiries across the UK (MBRRACE-UK) report on perinatal mortality, women from some minority ethnic backgrounds or who live in deprived areas have an increased risk of stillbirth and may need closer monitoring and additional support. The report showed that across all births (not just those which are preterm):

- compared with white babies (32 out of 10,000), the stillbirth rate is:
  - more than twice as high in black babies (72 out of 10,000)
  - around 50% higher in Asian babies (51 out of 10,000)
- compared with the least deprived areas (23 out of 10,000), the still birth rate is twice as high in the most deprived areas (47 out of 10,000). **[2022]**

Care of women at risk of preterm labour

1.2 Prophylactic vaginal progesterone and

prophylactic cervical cerclage

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. **[2019, amended 2022]**

  In April 2024, the only licensed preparation of progesterone for this indication was vaginal 200 mg capsules.

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 pregnancy that show a cervical length of 25 mm or less. **[2019, amended 2022]**

  In April 2024, the only licensed preparation of progesterone for this indication was vaginal 200 mg capsules.

1.2.3 When using vaginal progesterone, start treatment between 16+0 and 24+0 weeks of pregnancy and continue until at least 34 weeks. **[2019]**

1.2.4 Consider prophylactic cervical cerclage for women when results of a transvaginal ultrasound scan carried out between 16+0 and 24+0 weeks of pregnancy show a cervical length of 25 mm or less, who have had either:

- preterm prelabour rupture of membranes (P-PROM) in a previous pregnancy **or**

- a history of cervical trauma. **[2015, amended 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]**

For a short explanation of why the committee made these recommendations and how they might affect practice, see the rationale and impact section on prophylactic vaginal progesterone.

Full details of the evidence and the committee's discussion are in evidence review A: clinical effectiveness of prophylactic progesterone in preventing preterm labour.

1.3 Diagnosing preterm prelabour rupture of membranes (P-PROM)

1.3.1 In a woman reporting symptoms suggestive of P-PROM, offer a speculum examination to look for pooling of amniotic fluid and:

- if pooling of amniotic fluid is observed, do not perform any diagnostic test but offer care consistent with the woman having P-PROM (see the sections on antenatal prophylactic antibiotics for women with P-PROM, identifying infection in women with P-PROM and maternal corticosteroids)
- if pooling of amniotic fluid is not observed, perform an insulin-like growth factor binding protein-1 test or placental alpha-microglobulin-1 test of vaginal fluid. **[2015, amended 2019]**

1.3.2 If the results of the insulin-like growth factor binding protein-1 or placental alpha-microglobulin-1 test are positive, do not use the test results alone to decide what care to offer the woman, but also take into account her clinical condition, medical and pregnancy history and gestational age, and either:

- offer care consistent with the woman having P-PROM (see the sections on antenatal prophylactic antibiotics for women with P-PROM, identifying infection in women with P-PROM and maternal corticosteroids **or**

- re-evaluate the woman's diagnostic status at a later time point. **[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]**

1.3.4 Do not use nitrazine to diagnose P-PROM. **[2015]**

1.3.5 Do not perform diagnostic tests for P-PROM if labour becomes established in a woman reporting symptoms suggestive of P-PROM. **[2015]**

1.4 Antenatal prophylactic antibiotics for women with P-PROM

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]**

1.4.2 For women with P-PROM who cannot tolerate erythromycin or in whom erythromycin is contraindicated, consider an oral penicillin for a maximum of 10 days or until the woman is in established labour (whichever is sooner). **[2015, amended 2019]**

1.4.3 Do not offer women with P-PROM co-amoxiclav as prophylaxis for intrauterine infection. **[2015]**

1.4.4 For guidance on the use of intrapartum antibiotics, see the section on intrapartum antibiotics in NICE's guideline on neonatal infection, and when applicable also see the section on treatment for women with prolonged prelabour rupture of membranes who have group B streptococcal colonisation, bacteriuria or infection. **[2015]**