Emergency cervical cerclage

Recommendation 1.6.4

Why the committee made the recommendation

The recommendation on ensuring a plan is in place for removal of the suture when emergency cervical cerclage is used was made in response to an NHS England safety report, which highlighted some instances when removal did not happen.

How the recommendation might affect practice

The recommendation is not expected to affect practice.

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Repeat courses of maternal corticosteroids

Recommendations 1.9.4 to 1.9.6

Why the committee made the recommendations

There was some evidence that repeat doses of maternal corticosteroids reduce birthweight, but the absolute reductions in birthweight were small, with a mean difference in birthweight of 114 g between women receiving repeat courses and women receiving a single course. Subgroup analyses showed reductions were seen when corticosteroids were administered at lower gestational ages (below 30 weeks), when administered at intervals of less than 7 days, and when higher doses of more than 24 mg (total dose of repeat course) were administered. There was also a significant trend for reducing birthweight as the number of repeat courses increased. There was no evidence of benefit of maternal corticosteroids on chronic lung disease, but the committee were aware of a benefit seen with the need for respiratory support in neonates, although this outcome had not been prioritised for inclusion in the review. There was good evidence that repeat courses of maternal corticosteroids had no effect or beneficial effects on perinatal mortality, neonatal admission, intraventricular haemorrhage, growth at 2 years and neurodevelopmental delay. The committee agreed that a single repeat course may be beneficial in certain circumstances, when the previous course had been given more than

7 days previously and preterm birth was imminent, but that with multiple repeat courses the effects on birthweight may outweigh the benefits. However, the committee agreed that corticosteroids administered for other reasons during pregnancy would not count towards this total of 2 courses, and so clarified in their recommendation that only courses administered for preterm labour should be counted.

The committee were concerned with the lack of evidence for longer-term neurodevelopmental and growth outcomes beyond 2 years and lack of evidence on the optimal dose and interval for the repeat corticosteroids and so made a recommendation for research.

How the recommendations might affect practice

The recommendations provide guidance on when a single repeat course of maternal corticosteroids may be used, and so may reduce variation in practice. This may increase the number of women who receive a single repeat course, and may reduce the number of multiple (more than 2) courses of maternal corticosteroids given. The cost impact is therefore likely to be minimal considering the low cost of a course of maternal corticosteroids and the relatively small population of women for whom this will be considered.

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Context

Preterm birth is the single biggest cause of neonatal mortality and morbidity in the UK. Over 52,000 babies (around 7.3% of live births) in England and Wales in 2012 were born preterm (that is, before 37+0 weeks of pregnancy). There has been no decline in the preterm birth rate in the UK over the last 10 years.

Babies born preterm have high rates of neonatal and infant mortality, and the risk of mortality increases as gestational age at birth decreases. Babies who survive preterm birth have increased rates of disability. Recent UK studies comparing cohorts born in 1995 and 2006 have shown improved rates of survival (from 40% to 53%) for extreme preterm births (born between 22 and 26 weeks). Rates of disability in survivors were largely unchanged over this time period.

The major long-term consequence of prematurity is neurodevelopmental disability. Although the risk for the individual child is greatest for those born at the earliest gestational ages, the global burden of neurodevelopmental disabilities depends on the number of babies born at each of these gestations, and so is greatest for babies born between 32 and 36 weeks, less for those born between 28 and 31 weeks, and least for those born at less than 28 weeks gestation.

Around 75% of preterm births occur after preterm labour, which may or may not be preceded by preterm prelabour rupture of membranes. The remaining women giving birth preterm have an elective preterm birth when this is thought to be in the fetal or maternal interest (for example, because of extreme growth retardation in the baby or maternal conditions such as pre-eclampsia).

This guideline reviews the evidence for the best way to provide treatment for women who present with symptoms and signs of preterm labour, and women who are scheduled to have an early planned birth. It also reviews how preterm birth can be optimally diagnosed when symptoms are present, given that many women thought to be in preterm labour on a clinical assessment will not give birth preterm.

The guideline does not cover who should and should not have medically indicated preterm birth, or diagnostic or predictive tests in asymptomatic women.

Finding more information and committee details

To find out what NICE has said on topics related to this guideline, see the NICE topic page on intrapartum care.

For full details of the evidence and the guideline committee's discussions, see the evidence reviews and full guideline. You can also find information about how the guideline was developed, including details of the committee.

NICE has produced tools and resources to help you put this guideline into practice. For general help and advice on putting NICE guidelines into practice, see resources to help you put NICE guidance into practice.

Update information

June 2022: We have reviewed the evidence and made new recommendations on the use of repeat courses of maternal corticosteroids. These recommendations are marked **[2022].**

Recommendations that have been deleted, or changed without an evidence review

Some recommendations have been deleted from the 2015 guideline. Appendix 1 sets out these recommendations and includes details of replacement recommendations. If there is no replacement recommendation, an explanation for the deletion is given.

Some recommendations from the 2015 guideline have been amended with changes that could affect the intent without reviewing the evidence. These are labelled **[2015, amended 2022]**. Appendix 2 sets out these recommendations and includes details of the revised recommendations and the reasons for the changes.

August 2019: We have reviewed the evidence and made new recommendations on the effectiveness of prophylactic vaginal progesterone and prophylactic cervical cerclage for preterm labour and birth. These recommendations are marked **[2019]**.

We have also made some changes without an evidence review:

- updated recommendations to show cervical length of 25 mm or less as indicative of a high risk of preterm birth for consistency
- updated licensing information for erythromycin and magnesium sulfate use during pregnancy
- updated the time period when corticosteroids are offered to women with suspected preterm labour to reflect current practice
- updated advice on insulin-like growth factor binding protein 1 test or placental alpha-microglobulin 1 testing in preterm rupture of membranes to remove the word 'consider', making it clearer when the tests should be used.

These recommendations are marked **[2015, amended 2019]**.