SMFM Preterm Birth Toolkit

Singleton with prior sPTB Algorithm

Society for Maternal • Fetal Medicine

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Current singleton pregnancy with a Prior Spontaneous Preterm Birth

Prior singleton live birth 16^0-36^6 weeks gestation due to labor, ruptured membranes, cervical dilation / insufficiency, abruption*

Recommend 250 mg IM weekly 17-alpha hydroxyprogesterone caproate (initiate at 16 weeks, through 36 weeks)

Serial Transvaginal Ultrasound for CL *** (first at 16 weeks; until 23 6/7 weeks)

CL ≥30 mm

> CL ≤25 mm

Sterile speculum examination, Evaluate for labor, intraamniotic infection, etc.

CL ≥30 mm

<24 weeks

Yes

Routine prenatal care, continue 17P

No

CL 26-29 mm

<24 weeks

Yes

Routine prenatal care, continue 17P

No

CL ≤25 mm

Offer ultrasound indicated cerclage, continue 17P

CL ≥30 mm

<24 weeks

Yes

Routine prenatal care, continue 17P

No

CL 26-29 mm

<24 weeks

Yes

Routine prenatal care, continue 17P

No

CL ≤25 mm

Sterile speculum examination, Evaluate for labor, intraamniotic infection, etc.

* Women with a history of abruption related to preterm labor and pprom, or unrelated to other obvious causes (e.g., IV drug use, polyhydramnios) may be candidates for 17P. Careful review of historical factors and review of prior delivery records is imperative.

**For most women with CL ≥30 mm, q2 week ultrasound evaluation is appropriate.

*** Should be performed by credentialed sonographer or credentialed physician and interpreted by trained/credentialed physician.
Disclaimer

This algorithm and key driver material was written by a group of experts in the field of Preterm Birth. It was then reviewed by the Society for Maternal-Fetal Medicine's (SMFM's) Publications Committee, Executive Committee and Risk Management.

Standardization of healthcare processes and reduced variation has been shown to improve outcomes and quality of care. SMFM developed these documents to help facilitate the standardization process. These algorithms and key driver documents are “tools” to assist clinicians and practices. The practice of medicine continues to evolve, and individual circumstances may vary. They reflect clinical and scientific advances as of the date issued and are subject to change. They are not intended to dictate a certain management or course of action. We encourage users to adapt them to their particular situation, environment and patient population.

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