PIPADOR REVISION

MRCOG Part 1 Revision Notes

Preterm Labour

CLINICAL MANAGEMENT • LECTURE 468

VISUAL EXAMINATION REVISION NOTES

2026 Edition

468

MRCOG PART 1 REVISION NOTES | CLINICAL MANAGEMENT

Preterm Labour

Definitions, diagnosis, management and prevention of preterm labour (NICE NG25, RCOG GTG 75)

< 37 weeks	≈ 8%	Nifedipine	≤ 15 mm
Preterm birth	UK births	First-line tocolytic	Cervical length — preterm labour

■ KEY FACTS: Learning objectives

- Define preterm birth and its categories, and suspected vs diagnosed preterm labour.
- Describe diagnosis and management of preterm labour (NICE NG25, updated 2022).
- Describe prediction and prevention: progesterone, cervical cerclage (RCOG GTG 75) and preterm birth clinics.

468.1 Key definitions

Term	Definition
Preterm birth	• Birth before 37+0 weeks: extremely preterm < 28 wk • Very preterm 28–31+6 • Moderate/late preterm 32–36+6
Suspected preterm labour	Symptoms of labour with intact membranes but cervical change not yet confirmed
Diagnosed preterm labour	Suspected preterm labour plus progressive cervical change, or positive diagnostic test (TVS cervical length ≤ 15 mm or fFN ≥ 50 ng/mL)
Fetal fibronectin (fFN)	Glycoprotein in cervicovaginal fluid — a negative test has a high negative predictive value
Cervical cerclage	Suture placed around the cervix: history-, ultrasound- or rescue (emergency) indicated
Neuroprotection	Magnesium sulphate before preterm birth reduces cerebral palsy

■ IN PLAIN ENGLISH: Preterm labour

Preterm birth is the leading cause of neonatal death and disability. If labour cannot be stopped, the aim is to **buy time** for steroids, magnesium and transfer to the right neonatal unit — and to **prevent** recurrence in the next pregnancy.

468.2 Risk factors

- Previous preterm birth or mid-trimester loss (strongest)
  - Previous cervical surgery (LLETZ depth), uterine anomaly, short cervix
  - Multiple pregnancy, PPROM
  - Infection (BV, UTI), APH, smoking, low BMI, deprivation
  - Young maternal age

  - Short inter-pregnancy interval, IVF.
- Iatrogenic (planned) preterm births ≈ 1/3 (PE, FGR); spontaneous ≈ 2/3.

468.3 Diagnosis

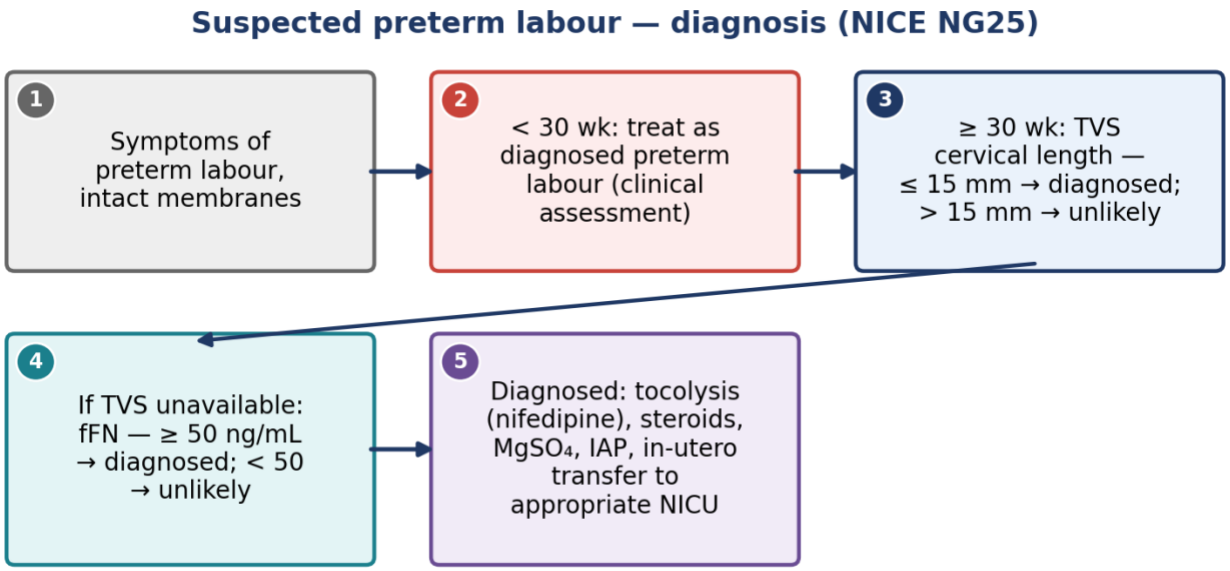


Figure 468.1 — Diagnosing preterm labour

468.4 Management

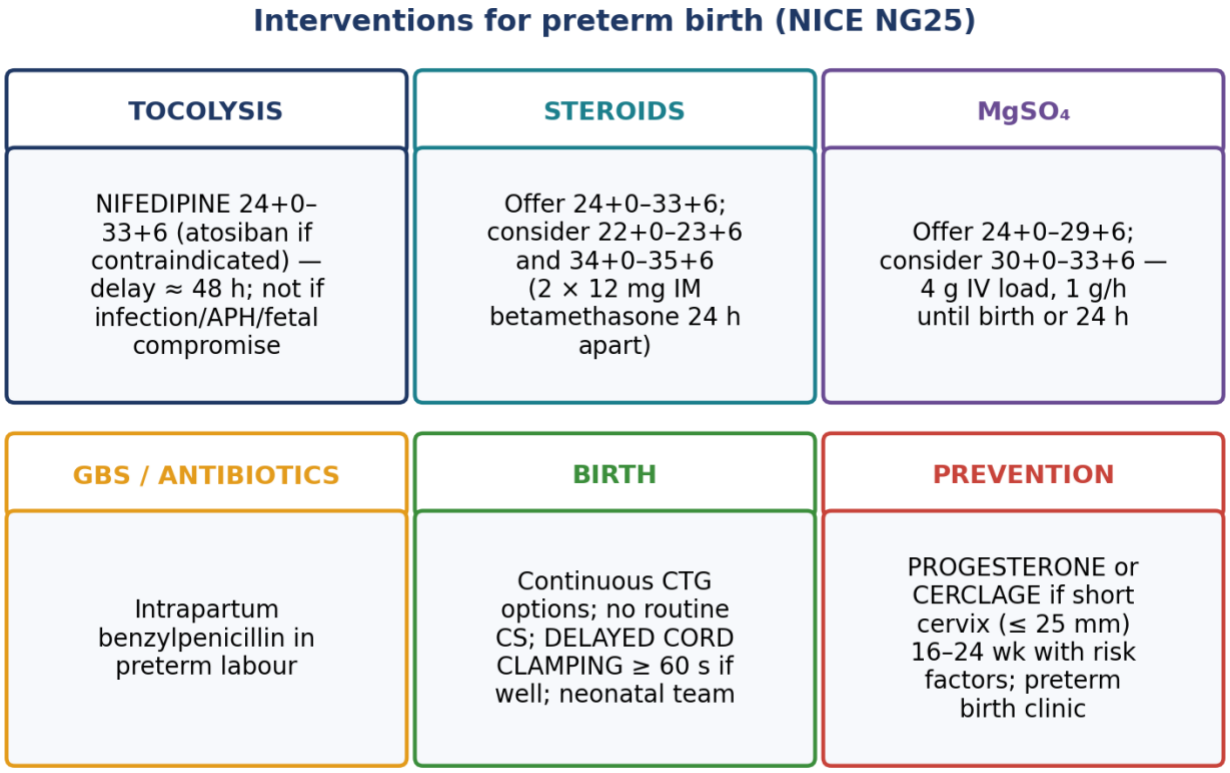


Figure 468.2 — Interventions

Topic	NICE NG25 recommendation
Tocolysis	• Nifedipine for suspected/diagnosed preterm labour 24+0–33+6 wk (oxytocin receptor antagonist if nifedipine contraindicated) • Not if PPROM, APH, infection, fetal compromise
Corticosteroids	• Offer 24+0–33+6 • Consider 22+0–23+6 (discussion with neonatology) and 34+0–35+6 • Consider repeat course only in specific circumstances
$MgSO_4$	• Offer 24+0–29+6 • Consider 30+0–33+6 (4 g IV over 15 min, 1 g/h until birth or 24 h)
Antibiotics	Intrapartum benzylpenicillin (GBS) in preterm labour
Place of birth	In-utero transfer to unit with appropriate NICU level (e.g. < 27 wk or < 800 g → level 3)
Fetal monitoring	Discuss options; continuous CTG not mandatory; FBS not < 34 weeks
Mode of birth	• Vaginal birth generally • CS for usual indications • Consider CS for breech 26–36+6
Cord clamping	• Wait at least 60 s if baby and mother are stable • Cord milking not < 28 weeks

468.5 Prediction and prevention

Situation	Prevention (NICE NG25, RCOG GTG 75)
History of spontaneous preterm birth or mid-trimester loss (16–34 wk) AND cervix ≤ 25 mm at 16–24 wk	Offer EITHER prophylactic vaginal progesterone OR cervical cerclage
No history, cervix ≤ 25 mm at 16–24 wk	Offer vaginal progesterone
History of PPROM or cervical trauma + short cervix	Consider cerclage
≥ 3 previous preterm births/mid-trimester losses	Offer history-indicated cerclage at 12–14 weeks
Dilated cervix, intact membranes, 16–27+6 wk	Consider rescue cerclage (avoid if infection, bleeding, contractions)
Previous failed vaginal cerclage	Consider transabdominal cerclage (pre-conception or early pregnancy)
Service	• Preterm birth prevention clinics (SBL v3 element 5) • Smoking cessation • Treat ASB

■ COMMON PITFALLS

Using tocolysis when infection or abruption is suspected.

Missing the window for steroids/$MgSO_4$.

Not transferring in utero to an appropriate neonatal unit.

468.6 Must-know summary

■ EXAM TIP

- Preterm < 37 wk; < 30 wk treat as diagnosed; ≥ 30 wk: TVS CL ≤ 15 mm (or fFN ≥ 50) = diagnosed.
- Nifedipine tocolysis; steroids 24–33+6 (consider 22–23+6, 34–35+6); $MgSO_4$ 24–29+6 (consider to 33+6); GBS IAP.
- Delayed cord clamping ≥ 60 s; in-utero transfer.
- Prevention: progesterone or cerclage for short cervix ± history; history-indicated cerclage after ≥ 3 losses.

■ MNEMONIC / MEMORY AID

Preterm bundle — 'Nifedipine, Steroids, Magnesium, Penicillin, Place, Pause (cord)'.