AUSTRALIAN
Preterm Birth
Prevention
ALLIANCE

Preterm Birth

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MBBS, FRANZCOG

Medical Lead Preterm Prevention Project

Consultant Obstetrician Gynaecologist WCH

Private Obstetrician and Gynaecologist – Belong O&G

Government of South Australia

SA Health

Declarations - My different hats

- Medical lead of the SA Preterm Birth Prevention project
  - Funded through Federal Government, Women's and Infant's Research Foundation and SAHMRI
- Consultant Obstetrician & Gynaecologist
  - *Women's and Children's Hospital*
- Obstetrician and Gynaecologist
  - *Belong O&G*

AUSTRALIAN Preterm Birth Prevention ALLIANCE

Women's and Children's Hospital ADELAIDE

BELONG &G

SA Health

To start

- A few questions…

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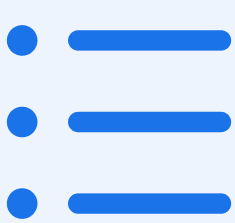

What percentage of births are preterm in Australia?

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What is a 'short cervix' at morphology ultrasound?

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Preterm birth: what you need to know

Up to **10%** of births in Australia are preterm.

This figure is significantly higher in developing countries.

Worldwide **13.4 million babies** are born preterm each year.

More than **26,000** Australian babies are born preterm each year.

The rate of preterm birth for Aboriginal mothers is almost **DOUBLE** that of non-Aboriginal mothers.

In 2020, preterm birth was responsible for nearly **1 million deaths worldwide** – World Health Organization.

The annual cost of preterm birth to Australia is **$1.4 billion**

More than $350 million is spent each year on those needing education assistance due to their early birth.

Preterm birth is the **leading cause of death and disability** in children up to five years of age in the developed world.

Preterm birth

is defined as birth before 37 and after 20 completed weeks of pregnancy.

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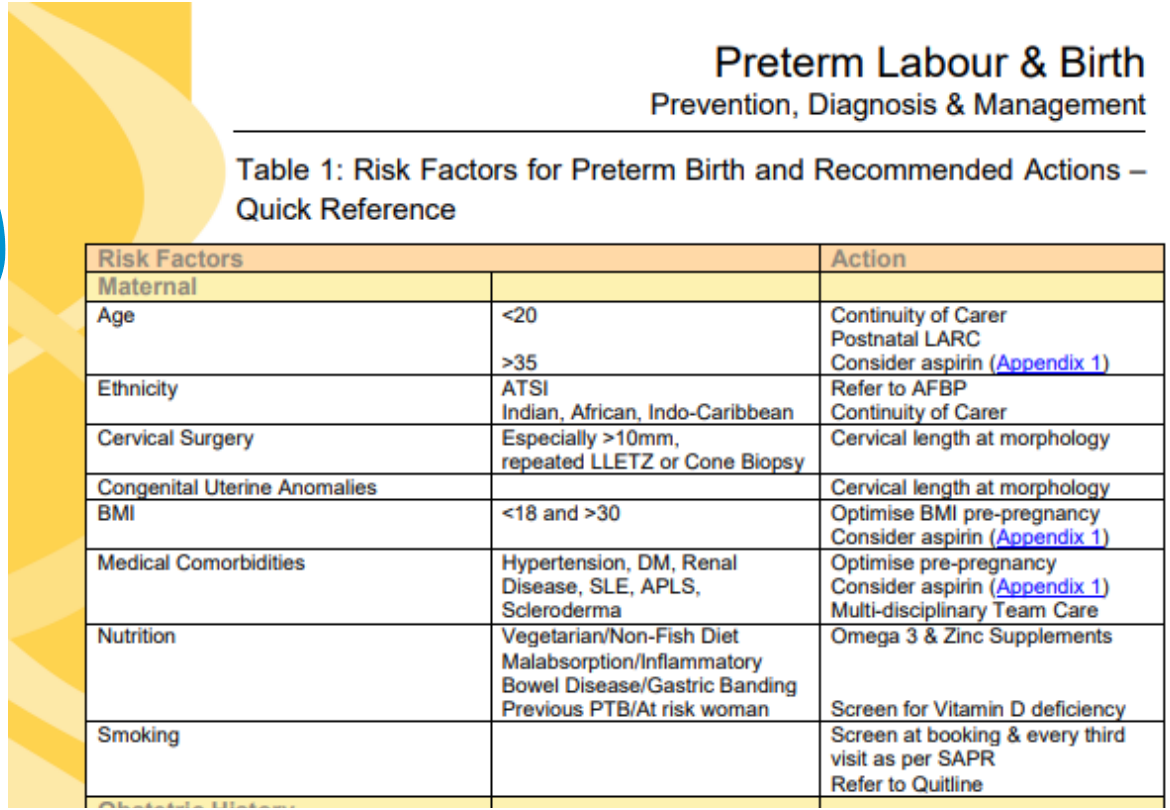
Preterm birth risk factors



Preterm Labour & Birth
Prevention, Diagnosis & Management

Table 1: Risk Factors for Preterm Birth and Recommended Actions – Quick Reference

Risk Factors		Action
Maternal		
Age	<20 >35	Continuity of Carer Postnatal LARC Consider aspirin (Appendix 1)
Ethnicity	ATSI Indian, African, Indo-Caribbean	Refer to AFBP Continuity of Carer
Cervical Surgery	Especially >10mm, repeated LLETZ or Cone Biopsy	Cervical length at morphology
Congenital Uterine Anomalies		Cervical length at morphology
BMI	<18 and >30	Optimise BMI pre-pregnancy Consider aspirin (Appendix 1)
Medical Comorbidities	Hypertension, DM, Renal Disease, SLE, APLS, Scleroderma	Optimise pre-pregnancy Consider aspirin (Appendix 1) Multi-disciplinary Team Care
Nutrition	Vegetarian/Non-Fish Diet Malabsorption/Inflammatory Bowel Disease/Gastric Banding Previous PTB/At risk woman	Omega 3 & Zinc Supplements Screen for Vitamin D deficiency
Smoking		Screen at booking & every third visit as per SAPR Refer to Quitline

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Omega 3

- Now part of SAMSAS panel of bloods for women having cFTS
  - Recommended to screen for levels <20 weeks
  - Initial research phase for ongoing funding
- Cochrane review:
  - 11% reduction in PTB
  - 42% reduction in early preterm births
- ORIP RCT – Omega-3 to Reduce the Incidence of Preterm Birth
- Avoid supplementation in women on clexane (safe for use with aspirin)

Omega-3 status test results: how to advise women

Omega-3 status[4,5]	Guidance to incorporate into pregnancy care plan
Less than 3.7% (low status)	**Take omega-3 fatty acid supplements** until 37 weeks, to reduce the risk of early preterm birth. Suggested dose: 800 mg DHA and 100 mg EPA per day. Typical suitable supplements include Infantem (Pharmamark)* and Omega Brain (Blackmores).
Between 3.7 and 4.3% (moderate status)	**No action required.** If already taking omega-3 fatty acids as part of a multivitamin and mineral supplement or a standalone supplement, this may continue.
Above 4.3% (sufficient status)	**Omega-3 supplements are not required** and provide no benefit to risk of early preterm birth. If women are already taking omega-3 fatty acids as part of a multivitamin and mineral supplement and wish to continue, the dose of DHA+EPA should not exceed 250 mg per day.

*Vegan algal oil supplement of DHA and EPA.

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Preterm birth risk factors

		Refer to Quitline
Obstetric History		
Previous preterm birth/PPROM/ cerclage/shortened cervix		Refer to Obstetrician/MFM
Previous fully dilated CS, STOP, GTOP		Cervical length at morphology
Pregnancy Features		
Shortened Cervix	<25mm on TVUS, especially <10mm or funnelling	Urgent referral to Obstetrician/ MFM
Short Interpregnancy Interval	Especially <6 but up to 18 months	Continuity of Carer Optimise nutrition & medical comorbidities Postnatal LARC
ART/IVF		Single Embryo Transfer Consider aspirin (Appendix 1)
Urogenital Infections	All Women Symptomatic Women History of infection associated losses and PTB e.g. chorioamnionitis	Screen, culture & treat UTI Culture & treat urogenital infections Refer to Obstetrician/MFM
Multiple pregnancy		Refer to Obstetrician. Refer to MFM if MCDA, DCDA complexity or higher multiple Consider aspirin (Appendix 1)
Social Factors		
Low SES/Intimate Partner Violence		Continuity of Carer Any available enhanced antenatal care programs Refer to Social Work if indicated
ATSI		Refer to AFBP
Substance abuse		Continuity of Carer Refer to Quitline/DASSA

Health

Preterm birth – the problems

For the mother

- Increased risk of obstetric intervention
- Separation from baby

For the baby

- Increased risk of death, cerebral haemorrhage, respiratory support, bowel necrosis and sepsis

For the children

- Increased risk of cerebral palsy, chronic lung disease, deafness, blindness, learning difficulties and behavioural problems

For the adults

- Increased risk of metabolic syndrome, diabetes, heart disease, loss of employment and social issues

National Preterm Birth Prevention Collaborative

AUSTRALIAN Preterm Birth Prevention ALLIANCE

- Grew from the WA Preterm Birth initiative which commenced in 2014
  - *AJOG 2017 – Reducing preterm birth by a statewide multifaceted program: an implementation study*
- Became national in June 2018
- The world's first national PTB prevention program
- 50+ maternity hospitals Australia wide participating
- NHMRC Partnership grant – supported by the Commonwealth Government
- Led by the Australian Preterm Prevention Alliance, in partnership with Women's Healthcare Australasia, the Institute of Healthcare Improvement (IHI) and Safer Care Victoria
- Aimed to strategically reduce the rate of preterm and early term births across Australia

National Preterm Birth Prevention Collaborative

Aim to reduce the rate of preterm and early term birth (37+0 to 38+6)

by 20% by March 2024

AUSTRALIAN Preterm Birth Prevention ALLIANCE

EVERY WEEK COUNTS

National Preterm Birth Prevention COLLABORATIVE

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Hospital sites participating in the Every Week Counts

National Preterm Birth Prevention Collaborative

50+ maternity hospitals working together to prevent preterm birth

Northern Territory

Royal Darwin and Palmerston Hospital

Western Australia

Albany Health Campus
Armadale Health Service
Broome Health Campus
Bunbury Hospital
Fiona Stanley Hospital
King Edward Memorial Hospital
Osborne Park Hospital

South Australia

Flinders Medical Centre
Lyell McEwin Hospital
Riverland Mallee Coorong Local Health Network
Women's and Children's Hospital

Victoria

Angliss Hospital
Box Hill Hospital
Ballarat Base Hospital
Frances Perry House
Frankston Hospital
Joan Kirner Women's & Children's Hospital
Latrobe Regional Hospital
Mercy Hospital for Women
Monash Medical Centre
Portland District Health
The Northern Hospital
The Royal Women's Hospital
University Hospital Geelong
Wangaratta District Base Hospital
West Gippsland Hospital
Wodonga Hospital

Queensland

Bundaberg Hospital
Darling Downs Health
Gold Coast University Hospital
Ipswich Hospital
Mater Mothers Hospital
Sunshine Coast University Hospital
The Royal Brisbane and Women's Hospital
Thursday Island Hospital
Townsville University Hospital

New South Wales

Campbelltown Hospital
Fairfield Hospital
Griffith Base Hospital
John Hunter Hospital
Royal Hospital for Women
Royal Prince Alfred Hospital
Southern NSW Local Health District
St George Hospital
Wagga Wagga Base Hospital
Westmead Hospital
Wollongong Hospital

Australian Capital Territory

Centenary Hospital for Women and Children

Tasmania

Launceston General Hospital
Royal Hobart Hospital

EVERY WEEK COUNTS

Australian Government Department of Health and Aged Care
Australian Preterm Birth Prevention Alliance
Women's Healthcare Australasia
Institute for Healthcare Improvement
SCV Safer Care Victoria
Women and Babies Research Sydney
women & infants research foundation

The key strategies to **prevent preterm birth**

More than 26,000 Australian babies are born too soon each year.

New research discoveries have led to the development of key strategies to safely lower the rate of preterm birth and are continuing to make pregnancies safer for women and their babies.

No pregnancy to be ended until at least 39 weeks unless there is obstetric or medical justification.

Measurement of the length of the cervix at all mid-pregnancy scans.

Use of natural vaginal progesterone (200mg each evening) if the length of cervix is less than 25mm.

If the length of the cervix continues to shorten despite progesterone treatment, consider surgical cerclage.

Use of vaginal progesterone if you have a prior history of spontaneous preterm birth.

Women who smoke should be identified and offered Quitline support.

To access continuity of care from a known midwife during pregnancy where possible.

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These strategies have been approved and endorsed by the Australian Preterm Birth Prevention Alliance.

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How can we reduce PTB….?
The Seven Strategies

1. No pregnancy to be ended until 39 weeks gestation unless there is obstetric or medical justification
2. Measurement of the length of the cervix at all mid-pregnancy scans
3. Vaginal progesterone 200mg each evening if the cervix is <25mm (TV)
4. If cervix continues to shorten, consider cerclage
5. **Vaginal progesterone if prior history of spontaneous preterm birth (or PPROM) **
6. Women who smoke should be identified and offered QUITline support
7. Promotion of continuity of care models

Strategy #1

No pregnancy to be ended until 39 weeks gestation unless there is obstetric or medical justification

- Aim for ‘PPG indicated’ inductions
- Change in standard elective CS booking timeframes
- Educate women regarding ‘Every Week Counts’

EVERY WEEK COUNTS

#letstalktiming
www.everyweekcounts.com.au
www.womenandbabiesresearch.com

Strategy #2

Measurement of the length of the cervix at all mid-pregnancy scans

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What cervical length is acceptable on a TA scan at morphology?

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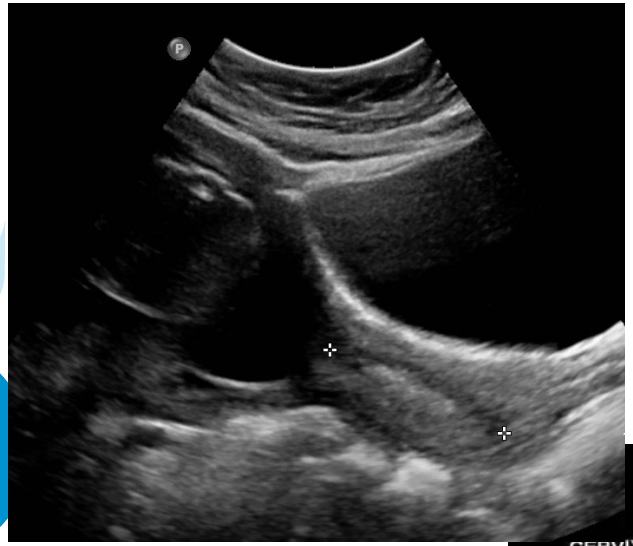
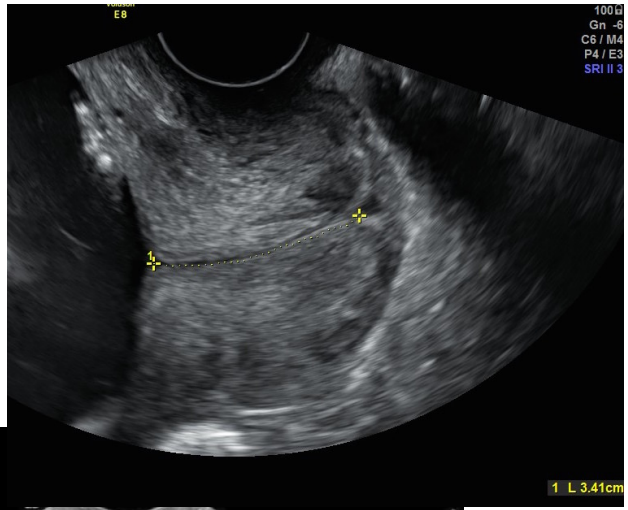
Ultrasound assessment of the cervix

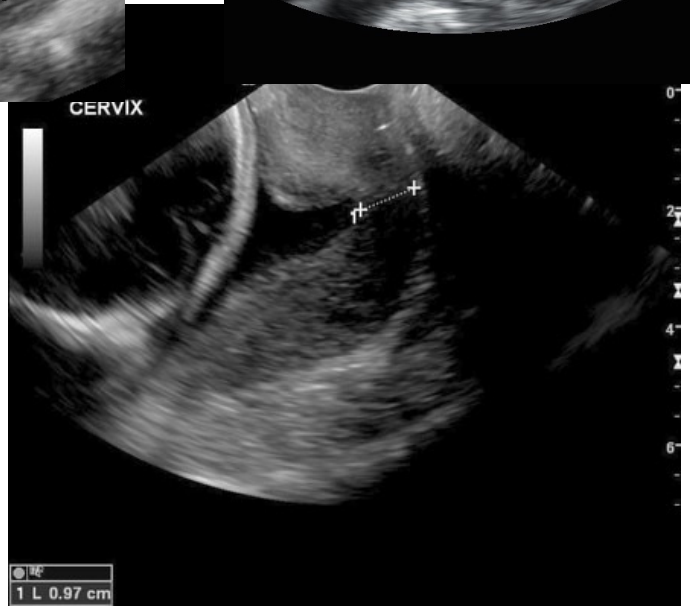
Measurement of CL included at all morph scans or any scans performed between 16-24 weeks

- A **TA** scan of **CL >35mm** adequate
- In all other cases TV scanning required
- Short = <25mm on TV ultrasound assessment

A TV cervical length <25mm in mid-trimester is associated with a 2.8x increased risk of delivering less than 34 weeks gestation







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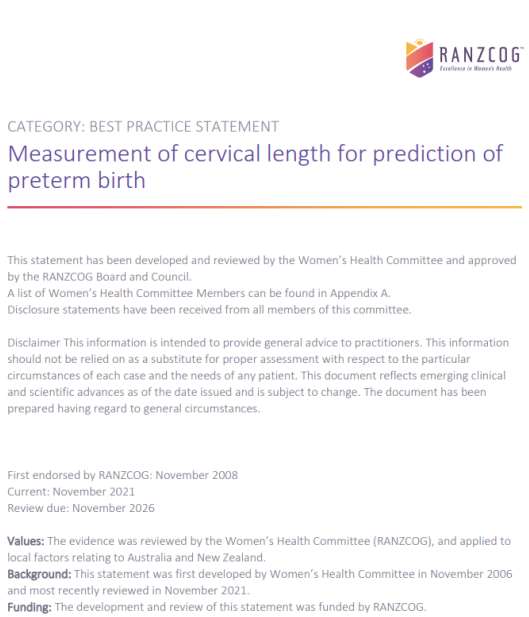
Ultrasound assessment of the cervix

- Practice statement first endorsed November 2008
- Recommendations November 2021
  - RANZCOG currently supports the use of initial TA screening of low risk women with singleton pregnancies at the mid-trimester scan, with additional transvaginal assessment for those with a short cervical length (TA CL <35mm)



RANZCOG
Excellence in Women's Health

CATEGORY: BEST PRACTICE STATEMENT

Measurement of cervical length for prediction of preterm birth

This statement has been developed and reviewed by the Women's Health Committee and approved by the RANZCOG Board and Council.
A list of Women's Health Committee Members can be found in Appendix A.
Disclosure statements have been received from all members of this committee.

Disclaimer This information is intended to provide general advice to practitioners. This information should not be relied on as a substitute for proper assessment with respect to the particular circumstances of each case and the needs of any patient. This document reflects emerging clinical and scientific advances as of the date issued and is subject to change. The document has been prepared having regard to general circumstances.

First endorsed by RANZCOG: November 2008
Current: November 2021
Review due: November 2026

Values: The evidence was reviewed by the Women's Health Committee (RANZCOG), and applied to local factors relating to Australia and New Zealand.
Background: This statement was first developed by Women's Health Committee in November 2006 and most recently reviewed in November 2021.
Funding: The development and review of this statement was funded by RANZCOG.

Strategy #3, #4 and #5

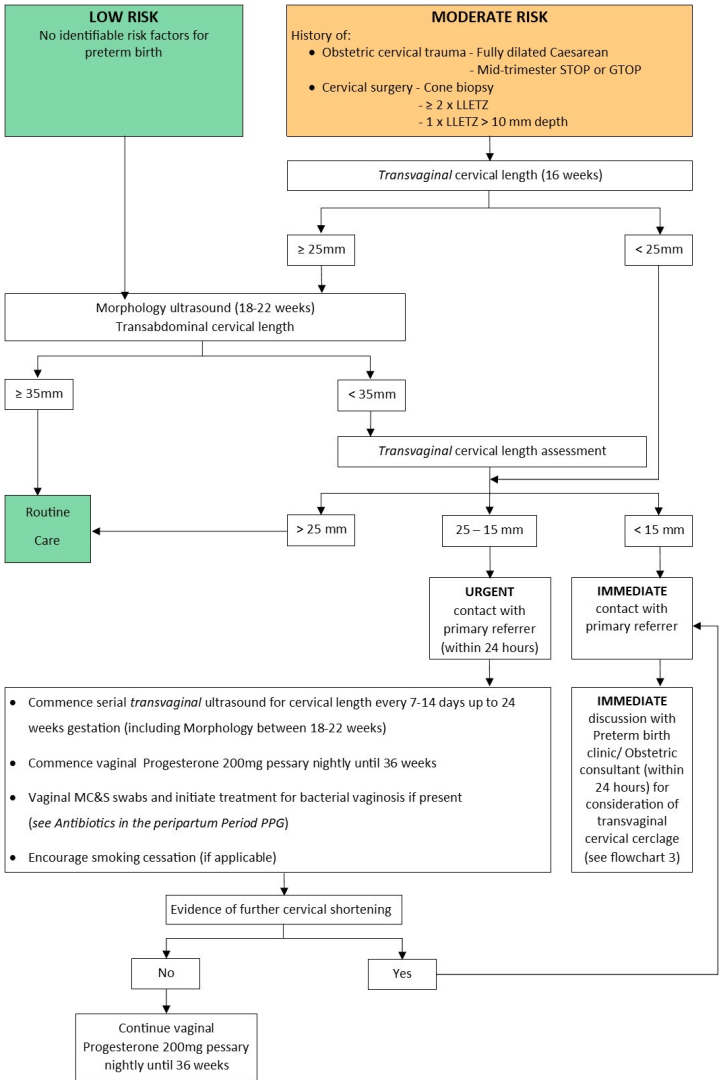
3. Vaginal progesterone 200mg each evening if the cervix is <25mm (TV)

4. If cervix continues to shorten, consider cerclage

5. **Vaginal progesterone if prior history of spontaneous preterm birth (or PPROM) **

PPG – Short Cervical Length and Cerclage

- Draft updated flowcharts
- Currently out for final consultation


LOW RISK
No identifiable risk factors for preterm birth
MODERATE RISK
History of:
• Obstetric cervical trauma - Fully dilated Caesarean
- Mid-trimester STOP or GTOP
• Cervical surgery - Cone biopsy
- ≥ 2 x LLETZ
- 1 x LLETZ > 10 mm depth
Transvaginal cervical length (16 weeks)
≥ 25mm
< 25mm
Morphology ultrasound (18-22 weeks)
Transabdominal cervical length
≥ 35mm
< 35mm
Transvaginal cervical length assessment
Routine Care
> 25 mm
25 – 15 mm
< 15 mm
URGENT contact with primary referrer (within 24 hours)
IMMEDIATE contact with primary referrer
• Commence serial transvaginal ultrasound for cervical length every 7-14 days up to 24 weeks gestation (including Morphology between 18-22 weeks)
• Commence vaginal Progesterone 200mg pessary nightly until 36 weeks
• Vaginal MC&S swabs and initiate treatment for bacterial vaginosis if present (see Antibiotics in the peripartum Period PPG)
• Encourage smoking cessation (if applicable)
IMMEDIATE discussion with Preterm birth clinic/ Obstetric consultant (within 24 hours) for consideration of transvaginal cervical cerclage (see flowchart 3)
Evidence of further cervical shortening
No
Yes
Continue vaginal Progesterone 200mg pessary nightly until 36 weeks

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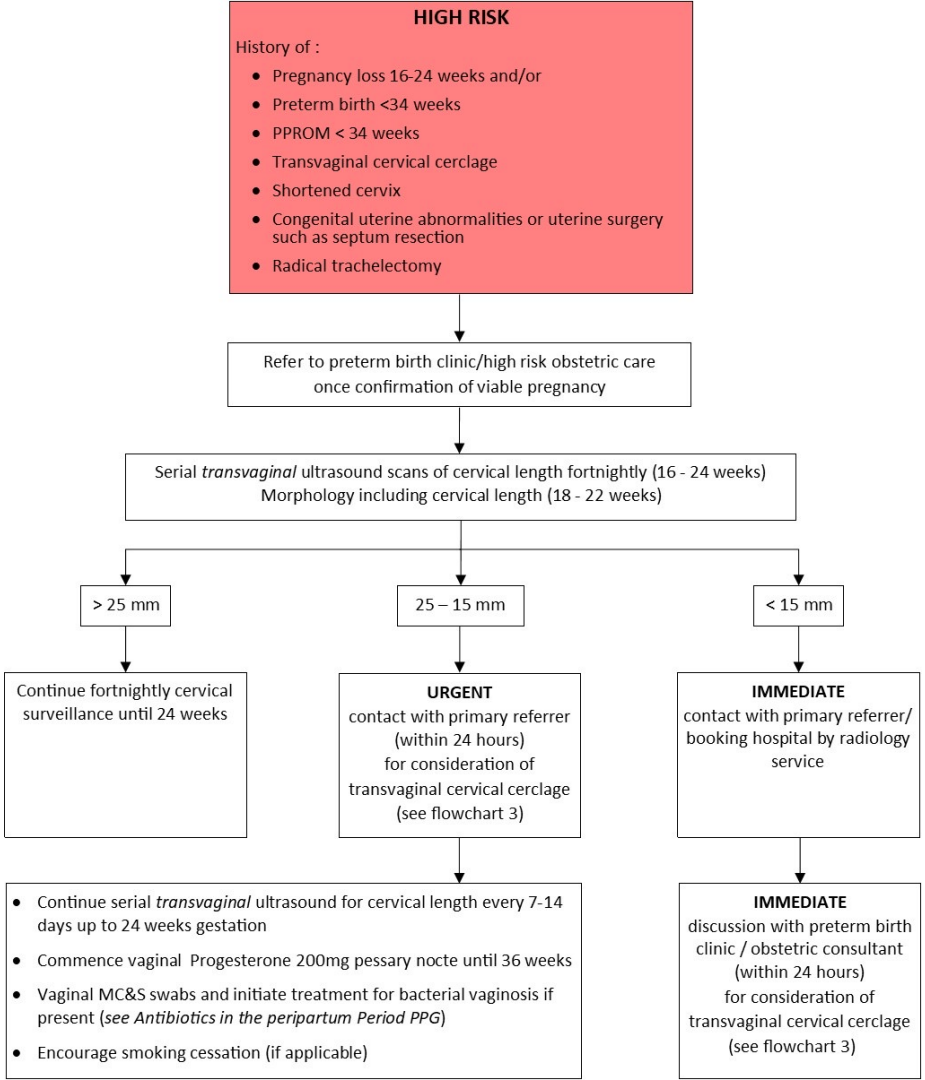
HIGH RISK
History of :
Pregnancy loss 16-24 weeks and/or
Preterm birth <34 weeks
PPROM < 34 weeks
Transvaginal cervical cerclage
Shortened cervix
Congenital uterine abnormalities or uterine surgery such as septum resection
Radical trachelectomy
Refer to preterm birth clinic/high risk obstetric care once confirmation of viable pregnancy
Serial transvaginal ultrasound scans of cervical length fortnightly (16 - 24 weeks)
Morphology including cervical length (18 - 22 weeks)
> 25 mm
25 – 15 mm
< 15 mm
Continue fortnightly cervical surveillance until 24 weeks
URGENT
contact with primary referrer (within 24 hours) for consideration of transvaginal cervical cerclage (see flowchart 3)
IMMEDIATE
contact with primary referrer/ booking hospital by radiology service
Continue serial transvaginal ultrasound for cervical length every 7-14 days up to 24 weeks gestation
Commence vaginal Progesterone 200mg pessary nocte until 36 weeks
Vaginal MC&S swabs and initiate treatment for bacterial vaginosis if present (see Antibiotics in the peripartum Period PPG)
Encourage smoking cessation (if applicable)
IMMEDIATE
discussion with preterm birth clinic / obstetric consultant (within 24 hours) for consideration of transvaginal cervical cerclage (see flowchart 3)

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Vaginal progesterone

- The exact mechanism of action of progesterone in preventing PTB is unknown
- Two main mechanisms;
  - Anti-inflammatory effect
  - Local increase in progesterone in gestational tissues
- Good safety profile

Vaginal Progesterone

PROGESTERONE

Source	General Schedule
Body System	GENITO URINARY SYSTEM AND SEX HORMONES > SEX HORMONES AND MODULATORS OF THE GENITAL SYSTEM > PROGESTOGENS

▸ Note

▾ ⚠ Authority Required (STREAMLINED)

11673

Prevention of preterm birth

Clinical criteria:

- Patient must have a singleton pregnancy,

AND

- Patient must have at least one of: (i) short cervix (mid-trimester sonographic cervix no greater than 25 mm), (ii) a history of spontaneous preterm birth,

AND

- The treatment must be administered no earlier than at 16 weeks gestation.

Code & Prescriber	Medicinal Product Pack (Name, form & strength and pack size)	Max qty packs	Max qty units	No. of repeats	DPMQ	Max Safety Net	General Patient Charge
12465C MP MW NP	PROGESTERONE progesterone 200 mg pessary, 15 (PI, CMI)	3	45	3	$127.89	$30.00	$30.00
	Available brands						
	Oripro						

Vaginal progesterone

- EPPPIC Study – Lancet 2021
- Systematic review of RCT comparing vaginal progesterone, IM 17-hydroxyprogesterone caproate, oral progesterone vs control or with each other in asymptomatic women at risk of PTB
- Primary outcomes – gestation at delivery, neonatal (composite of serious neonatal outcomes), maternal outcomes (HTN, PET, GDM, infection)
- >11, 000 participants

EPPPIC Study

Vaginal progesterone reduced risk of PTB <34 weeks in singleton pregnancy compared with control

- RR 0.78, CI 0.68-0.90
- If baseline risk of 20%, RR of 0.78 equates to an absolute risk reduction of 4.4%

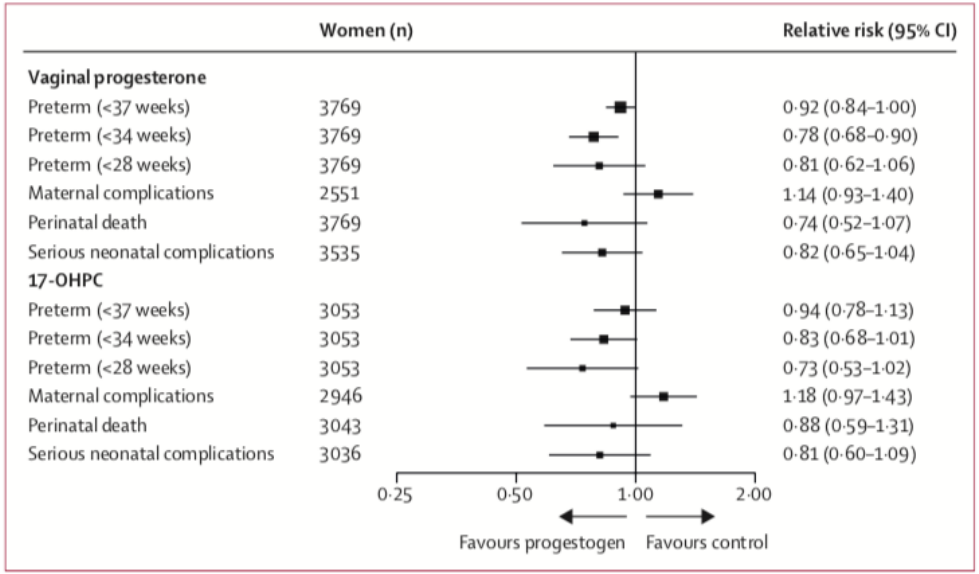
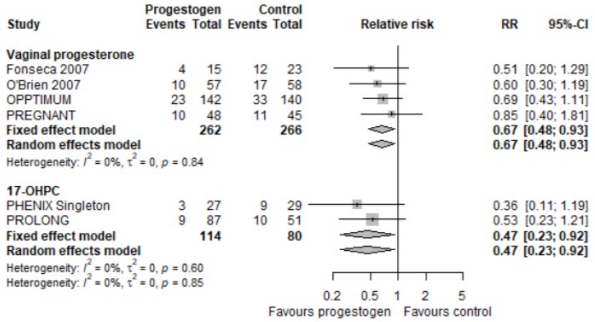


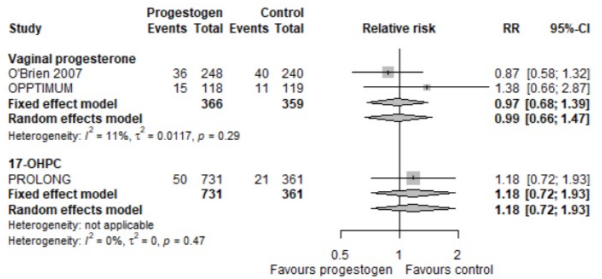
Figure 2: **Main outcomes in singleton pregnancies for vaginal progesterone and 17-OHPC trials**
17-OHPC=17-hydroxyprogesterone caproate. For vaginal progesterone: preterm birth <37 weeks number of events (n)=661, control n=705; preterm birth <34 weeks n=276, control n=343; preterm birth <28 weeks n=92, control n=111; maternal complications n=186, control n=171; perinatal death n=49, control n=64; serious neonatal complications n=119, control n=140. For 17-OHPC: preterm birth <37 weeks n=510, control n=330; preterm birth <34 weeks n=206, control n=158; preterm birth <28 weeks n=77, control n= 66; maternal complications n=285, control n=178; perinatal death n=57, control n=40; serious neonatal complications n=95, control n=75.

Short cervix (<=30mm)

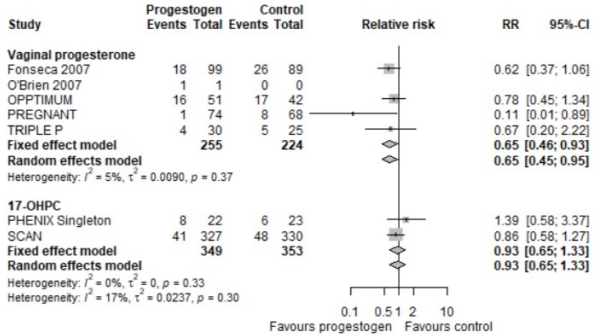
Non-short cervix (>30mm)

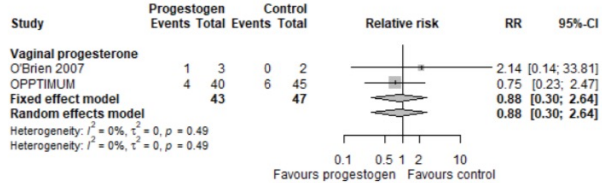
With PPTB





No PPTB





Appendix Figure 10: Analysis of subpopulations of participants defined according to categorised cervical length and presence of a previous PTB. These plots are based on considerably fewer data than the main analysis owing to unmeasured/unknown values for cervical length meaning that 6 trials (4 for VP, 2 for 17-OHPC) cannot be included. Different trials contribute to different subpopulation analyses and there may be differences between trials other than the factors by which they are grouped.

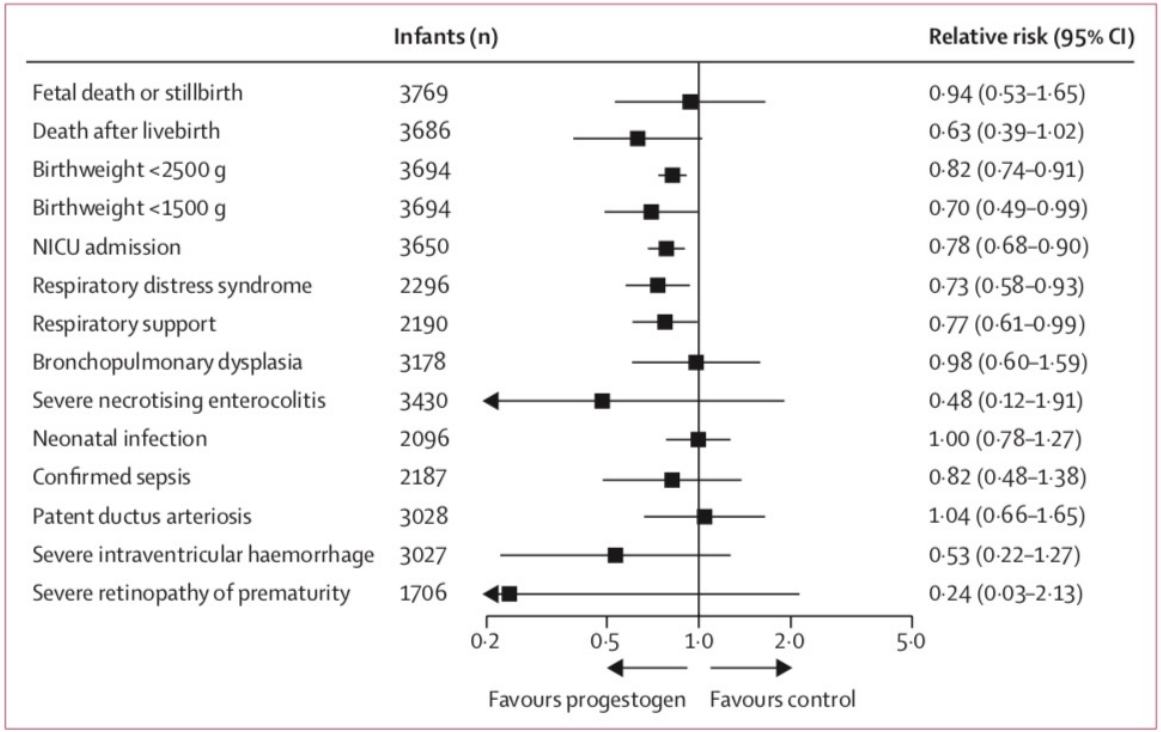
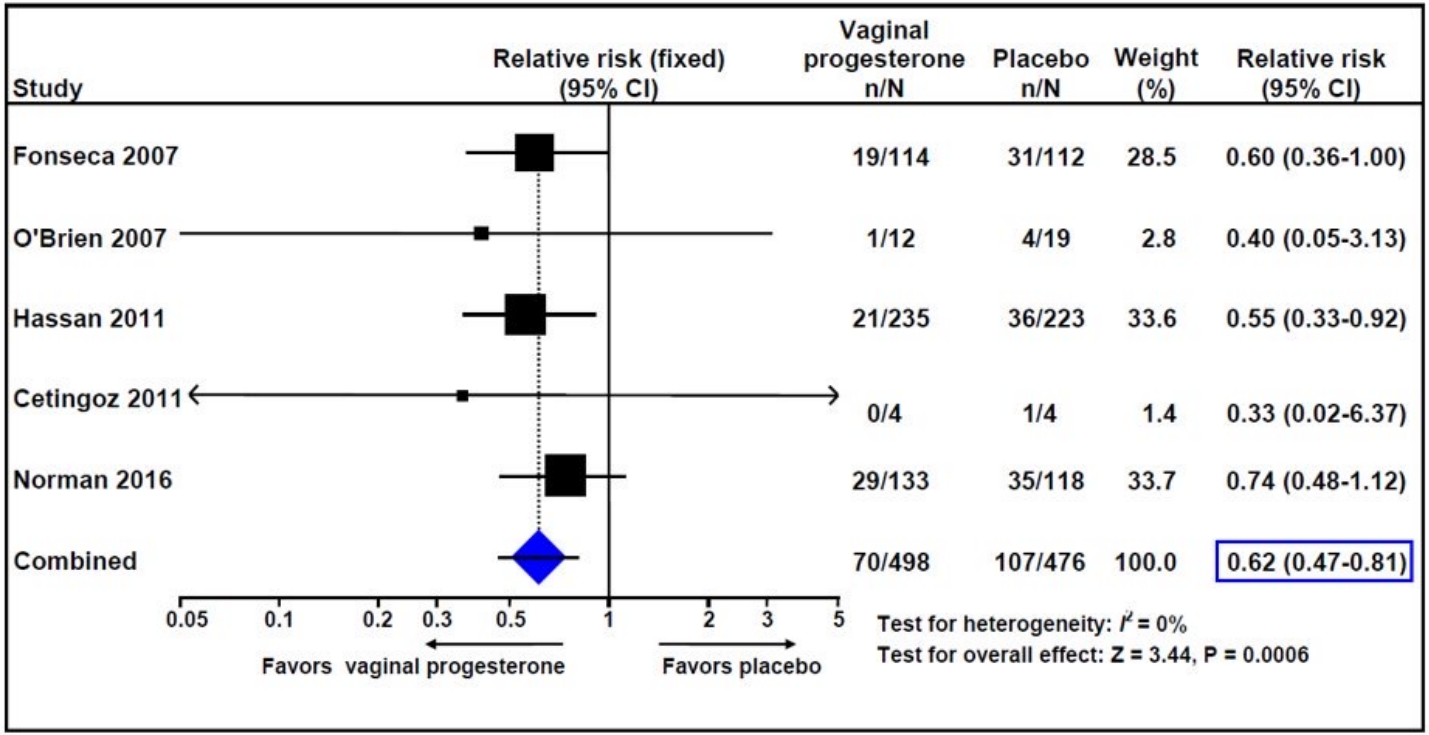


Figure 3: **Vaginal progesterone: additional neonatal outcomes in singleton pregnancies**
NICU=neonatal intensive care unit. Severe intraventricular haemorrhage was grade III or IV. Severe retinopathy of prematurity was stage 3 or worse. Severe necrotising enterocolitis was grade II or III. Fetal death or stillbirth number of events (n)=23, control n=24; death after livebirth n=26, control n=40; birthweight <2500 g n=442, control n=524; birthweight <1500 g n=131, control n=168; NICU admission n=286, control n=353; respiratory distress syndrome n=99, control n=132; respiratory support n=100, control n=128; bronchopulmonary dysplasia n=32, control n=32; severe necrotising enterocolitis n=3, control n=6; neonatal infection n=113, control n=111; sepsis n=25, control n=30; patent ductus arteriosis n=37, control n=35; severe intraventricular haemorrhage n=7, control n=13; retinopathy of prematurity n=1, control n=4.

Vaginal progesterone for short cervix



Meta-analysis IPD data

Romero et al, AJOG Feb 2018

Vaginal progesterone for short cervix

Hassan et al, Ultrasound Obstetrics and Gynaecology, 2011

- RCT, double blinded, placebo controlled study which looked at vaginal progesterone to reduce the rate of preterm birth in women with a sonographic short cervix
- Women with a short cervix treated with progesterone
  - 95% delivered > 28 weeks
  - 85% delivered > 35 weeks
  - 70% delivered > 37 weeks

Cervical Cerclage

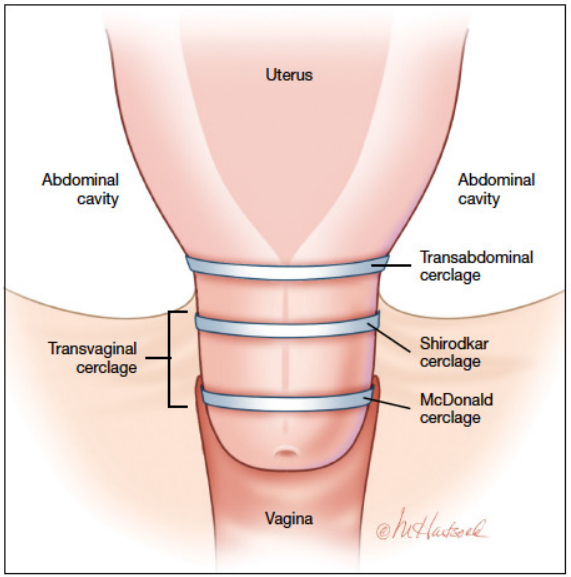
Indications

- History
  - 3 or more spontaneous PTB or mid-trimester pregnancy losses
  - Usually placed between 12-14 weeks (but can be inserted up to 24/40)
- Ultrasound indication
  - Previous PTB (<34 weeks) and CVL <25mm OR
  - No previous PTB and CVL <10-15mm
- Physical examination findings
  - Open cervix on examination
  - No evidence of active chorioamnionitis or active labour
  - Gestation <24 weeks

Cervical Cerclage

- Inserted usually between 14-24 weeks
- Removed at 36-37 weeks (or earlier if labour / ROM)
- Spinal anaesthetic
- Usually admitted for 1-2 nights
- Indomethacin and cephazolin for 24-48 hours
- McDonald or Shirodkar technique
- Suture materials include mersiline tape, prolene, nylon and silk

FIGURE 2 **Suture placement in transvaginal and transabdominal cerclage procedures**



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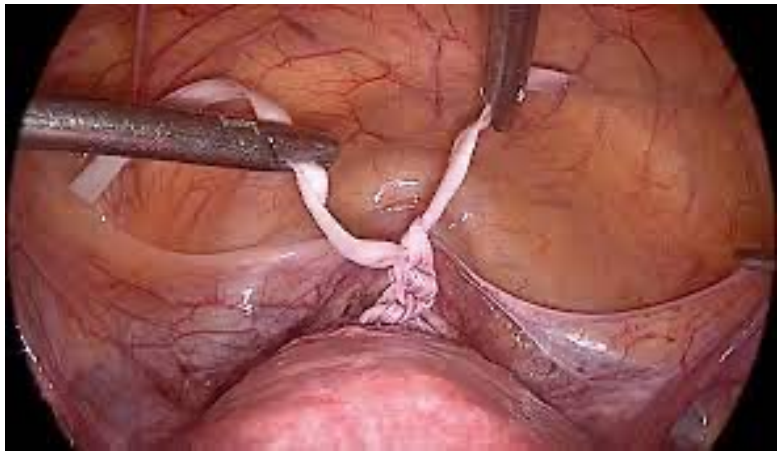
Cervical cerclage

Consider transabdominal cerclage if;

- Previous cervical surgery where there is no intravaginal cervix to suture
- History of failed cervical cerclage
- Placed pre-pregnancy or in early pregnancy
- Now offered laparoscopically (few clinicians only)
- Woman requires CS for delivery (suture not removed)



Strategy #6

Women who smoke should be identified and offered QUITline support

- Identify women who smoke at initial booking visit
- Refer to appropriate resources
- Offer nicotine replacement options
- Incentive programs in hospitals to encourage women to stop smoking - LMHS

Strategy #7

Promotion of continuity of care models

- Challenge of public heath systems
- Benefit of GP shared care model
- Able to be provided through a few models in public systems
  - AFBP
  - MGP
  - MFM
  - Community midwifery clinics

Women's and Children's Hospital

Preterm Birth Clinic - WCH

- Weekly clinic based in MFM unit at WCH
  - Staffed by Dr Rachel Earl, Dr Kate Andrewartha, (Dr Amanda Poprzeczny)
- Referral based clinic
- Aimed to provide continuity of care for high risk women through the early part of pregnancy
- Fortnightly ultrasound of cervical length from 14/15 weeks
- Facilitate commencement of progesterone or cervical cerclage if required
- Collect data on interventions and outcomes in this population and in conjunction with other PTB Clinic networks
- Returned to usual model of care from 23/24 weeks

Preterm birth clinic WCH

Women's and Children's Hospital

Referral criteria for PTB Clinic

- Previous spontaneous PTB <34 weeks gestation
- One or more spontaneous mid-trimester fetal loss (16-24 weeks)
- History of cervical / uterine surgery
  - Previous fully dilated caesarean section
  - 2 or more LLETZ
  - Cone biopsy
  - Radical trachelectomy
  - Resection of uterine septum or adhesions
- Uterine anomaly – bicornuate uterus, unicornuate uterus, uterus didelphys, septate uterus, fetal exposure to DES
- Incidental finding of short cervix on ultrasound
  - <15mm at dating scan (11-14 weeks)
  - <25mm before 24 weeks gestation including routine morphology ultrasound cervical length measurement
- Cervical cerclage in previous pregnancy
- Follow up of women who have had a cervical cerclage placed in current pregnancy
- Consultant obstetrician request

PRE TERM BIRTH (MFM PTB)

- ☐ Previous spontaneous preterm birth ≤ 34 weeks
- ☐ Previous mid-trimester fetal loss OR previous cervical cerclage OR previous fully dilated Caesarean Section
- ☐ Previous Cervical surgery – 2 or more LLetz OR 1 Cone biopsy OR Radica trachelectomy
- ☐ Mullerian developmental anomaly OR Uterine Surgery such as Septum resection
- ☐ Ultrasound short cervix in current pregnancy - ≤ 15 mm at dating scan (11-14 weeks) or ≤25mm before 28 weeks

Referral Form – Maternal Fetal Medicine

Women's and Children's Health Network
72 King William Road, North Adelaide SA 5006
Tel: 08 8161 9263 Fax: 08 8161 9264

Government of South Australia
SA Health

Dear (Dr's Name)_____

This referral has been discussed with (midwife/doctor) _____

PATIENT DETAIL

Name:_____

Address:_____

Date of Birth: _____ Phone:_____

Mobile: _____ Medicare Number:_____ Medicare Expiry: ____

Support person:_____ Phone: _____

Interpreter required: ☐ No ☐ Yes Language: _____

ATSI Status: ☐ No ☐ Yes, Aboriginal ☐ Yes, Torres Strait Islander ☐ Yes, Aboriginal & Torres Strait Islander

REFERRING PRACTITIONER DETAILS

Referring Doctor: _____

Provider Number:_____ Phone:_____

Address:_____

Signature:_____ Date: _____

The below information **MUST** be provided with this referral request.

CLINICAL INFORMATION/REASON FOR REFERRAL (Page 1 of 2)

Gravidity/Parity:	EDC:
☐ Fetal Anomaly	☐ Current/Previous Pregnancy Complications
☐ Complex Multiple Pregnancy	☐ ADACS Follow up
☐ Severe Maternal Medical Conditions	☐ Pre/Post-Pregnancy Counselling
☐ Early Pregnancy Care Coordination	☐ Abnormal Maternal Serum Screening
☐ Pre Term Birth	☐ Other – Please Specify
☐ **Copy of ALL Ultrasounds attached**	☐ **Copy of Antenatal bloods attached**
Additional Clinical information or reason for referral inc. Previous Obs Hx and previous surgery Hx	

SA Health

LMH and FMC

Lyell McEwin

- Women at risk are identified through initial referral or triage visit
- First visit with Consultant/Reg in High Risk Pregnancy Clinic
- Any patient with short cervix sent to WAU → management arranged
- On-call registrar available for phone advice re patient

FMC

- Referral faxed through to 8204 5210
- Tuesday Preterm birth clinic – review at 14-16 weeks
- Cervical length U/s booked
- Short cervix on u/s → patient sent to WAS for review (8-9pm) or call on-call registrar

What can I do to help?

- Identify women at risk early
- Identify risk factors for PTB and modify those that you can
- Ensure you check cervical length on morphology u/s
  - Request it if not routinely done by your radiology unit
  - Document in notes
  - Arrange further u/s monitoring, commence progesterone if CL <25mm or refer to MFM for consideration of cerclage
- Aim to gain gestation with those who are pre-term
- Aim to reduce early term deliveries
  - Changing of standard elective CS booking timeframe
  - Consult PPGs / other resources about best time for IOL (aim for evidence based IOL planning)
  - Discuss with patients regarding importance of the last few weeks of pregnancy – *Every Week Counts, Let's Talk Timing of Birth*

#LetsTalkTiming

Let's Talk Timing of Birth

Information to help you talk with your midwife or doctor about the best timing for your baby's birth.

Scan here to watch a video summarising the information in this brochure.

Safer Baby

Stillbirth Centre of Research Excellence

Australian Government Department of Health and Aged Care

Australian Preterm Birth Prevention Alliance

INFORMATION FOR HEALTHCARE PROFESSIONALS

Let's Talk Timing of Birth Resources

The 'Let's Talk Timing of Birth' resources have been co-designed and tested with women and maternity healthcare professionals to promote shared decision-making around timing of birth. These resources, which include a brochure for women and complementary video to be played in antenatal waiting rooms, provide information on the importance of timing birth at the appropriate gestational age, describe what a planned birth is, and when a planned birth might be considered. These resources also introduce the concept of stillbirth and risk factors that increase a woman's chance of stillbirth.

As healthcare professionals, we may be concerned that discussing stillbirth with women will cause fear and anxiety. The 'Let's Talk Timing of Birth' resources have been designed to introduce stillbirth in a sensitive manner and aid these discussions. Research has demonstrated that women do not want information withheld from them of fear that talking about stillbirth will frighten them. Discussing stillbirth as a rare event is important, as is informing women of the measures that they can take to reduce their chance of stillbirth (e.g. stopping smoking as soon as possible; attending all antenatal care appointments to monitor baby's health and growth; being aware of baby's movements from 28 weeks onwards and reporting any changes immediately to a doctor or midwife; going to sleep on their side from 28 weeks' onwards).

Talking it through

The 'Let's Talk Timing of Birth' brochure was developed to promote an open and shared discussion between a woman and her maternity healthcare professional, introducing stillbirth in a gentle manner. This discussion should start early in pregnancy, with the view that it would be revisited during pregnancy. The brochure was not developed to replace any other usual conversations or to be given without a discussion.

Every week counts

The 'Let's Talk Timing of Birth' resources also provide information on why every week of growth counts for a baby's health and development. Included in the brochure is a QR code leading to the Every Week Counts website.

Scan here to view the Every Week Counts website

Safer Baby Bundle

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Australian Government Department of Health and Aged Care

Australian Preterm Birth Prevention Alliance

Thank you

- Questions?

Government
of South Australia

SA Health