Preterm Labor: Prep room

Physical Examination / Labs:

- > Sterile speculum exam, cervical examination
- Wet mount
- > FFN (if nothing inside vagina >24 hours)
- ➤ UA with C&S
- ➤ Gonorrhea and Chlamydia Cultures
- ➤ GBS Culture
- > Ultrasound: EFW, AFI, Placental location, Presentation, cervix length
- NST, tocometry
- Pooling, nitrazine, ferning if also has loss of fluid

Orders:

Diagnosis	Or	ders	
<34 weeks		Admit to L&D	
		CEFM	
		Celestone 12 mg IM q 24 hours x 2 doses	
		Consider tocolysis (do not combine tocolytics):	
		o Nifedipine 10 mg po q 20 minutes x up	
		to 4 doses, then 10-20 mg po q 3-8	
		hours up to 24 hours, max 180 mg/d	
		o Terbutaline 0.25 mg SQ q 20-30	
		minutes up to 4 doses, hold if maternal	
		pulse >120 bpm	
		o Indomethacin 50 – 100 mg load, then 25 mg po q 4-6 hours x 48 hours max	
		• Check AFI daily	
		Consider Magnesium sulfate for neuroprotection	
		if <32 weeks (do not combine Procardia and Mg)	
		Magnesium 4 mg bolus then 2 g gtt q	
		hour x 18-24 hours	
		o Foley to gravity, strict I/O	
		o Check DTR and mental status q hour	
		o Magnesium levels q 6 hours	
		GBS Prophylaxis*	
		o PCN 5 million units IV q 4 hours x 48	
	_	hours	
		Consider NICU consultation if suspicion of	
	_	delivery is high	
		Treat UTI, BV if present	
>34 weeks		Same as above except	
		Omit magnesium sulfate for neuroprotection	
		Consider Celestone in selective cases	

Discharge:

- Resolution of contractions
- FFN negative with long cervix
- Serial cervix examination showing no progressive dilation
- Labor precautions, FKC's, need for compliance with scheduled followup
- Consider Progesterone therapy if history of preterm delivery and short cervix

CC: Contractions

Updated: 2/15/11

History:

- Cramping or Contractions
- Vaginal bleeding
- Leaking of fluid
- Recent coitus

Differential Diagnosis:

False labor, incompetent cervix

Necessary Documentation:

- > Frequency of contractions
- ➤ Category FHR tracing
- > EFW, pelvimetry
- Serial cervix examination

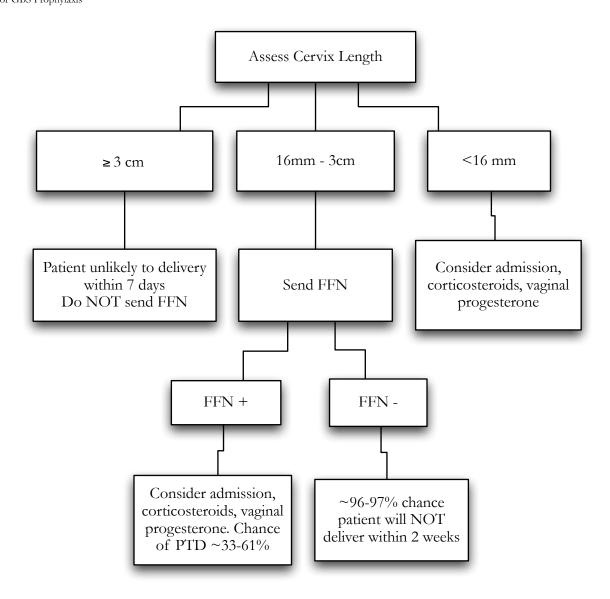
Notes:

- Pathogenesis of PTL: idiopathic, placental abruption, subclinical infection, over-distention of the uterus
- Consider admission strongly if: history of PTB, short cervix, +FFN

Preterm Labor: Prep room 1

This document is intended for educational purposes only. It does not reflect standard of care, and is not to replace clinical judgment, or expertise. It also does not represent policy for Women's Health at ARMC or RCRMC.

0 $\,$ 100 mg PV q HS vs 17-OH Progesterone 250 mg IM q week *see protocol for GBS Prophylaxis



Preterm Labor: Prep room 2