Preterm Labor: Prep room

CC: Contractions

Updated: 2/15/11

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	Orders
<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) o 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

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

- 100 mg PV q HS vs 17-OH Progesterone 250 mg IM q week

*see protocol for GBS Prophylaxis