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Royal College of Obstetricians & Gynaecologists

Information for you

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Premature labour

About this information

This information is for you if you want to know about premature labour. You may also find it useful if you had a baby born prematurely in a previous pregnancy. It may be helpful if you are a partner, relative or friend of someone who has been in this situation.

What is premature labour?

Labour is when regular contractions lead to opening up of the cervix (neck of the womb). This normally occurs at between 37 and 42 weeks of pregnancy. If it occurs before 37 weeks, it is known as premature labour.

In the UK, having a baby early is common: eight in 100 babies are born before 37 weeks. Very premature birth is much less common, with fewer than one in 100 babies being born at between 22 and 28 weeks of pregnancy.

About one-quarter of babies born prematurely are delivered early by the team looking after them because there are concerns about the health of the mother and/or baby. This is done either by having labour started off (being induced) or by having a caesarean section. However, most babies are born early because labour starts naturally sooner than it should.

What could premature birth mean for my baby?

Having a baby born early can be worrying and distressing for parents. Your doctor and/or midwife will be happy to talk to you about this and give you information about support groups that you might find helpful.

Premature babies have an increased risk of health problems, particularly with breathing, feeding and infection. The earlier your baby is born, the more likely he or she is to have these problems and your baby may need to be looked after in a neonatal unit. However, more than eight out of ten premature babies born after 28 weeks survive and only a small number will have serious long-term

disability. Many survivors (as children) who have long-term health problems still rate their quality of life as being good.

If you give birth before 24 weeks of pregnancy, it is sadly much less likely that your baby will survive. Babies who do survive after such a premature birth often have serious health problems. The possible treatment and outcomes for your baby in your individual situation will be discussed with you.

You will be supported to spend as much time as you can with your baby. Breast milk is very important for premature babies: the doctors and nurses will talk to you about this and provide any support you need.

What causes premature labour?

For most women, the cause of premature labour is not found. It is thought that a number of factors, sometimes involving infection, can bring about a change in the cervix that causes labour to start.

However, there are certain factors that increase the risk. These include if:

- your waters have broken early
- you have had a premature birth or your waters broke before 37 weeks, in a previous pregnancy
- you have had a previous late miscarriage (after 14 weeks of pregnancy)
- you have had vaginal bleeding after 14 weeks in this pregnancy
- you have an abnormality in the shape of your womb
- you are carrying twins or triplets
- you have excess fluid around your baby
- you have a short cervix
- you are a smoker
- you have had fertility treatment.

What happens if I think my labour may be starting early?

If you are having regular, painful tightenings or you think your waters have broken, it is important that you contact your maternity unit straight away. You are likely to be asked to come in.

Your doctor or midwife will ask whether you have had a premature birth in a previous pregnancy. You will also be asked about your general health, whether you have had any abdominal pain, tightenings or bleeding, and whether you think your waters have broken.

You will have a check-up that may include:

- a general examination and a check of your temperature, pulse and blood pressure
- an examination of your abdomen
- a check of your baby's heartbeat
- being asked to give a blood sample to check for signs of infection
- being asked for a urine sample for testing.

You may also be offered an ultrasound scan to check your baby's wellbeing and which way round he or she is lying.

The start of labour is usually diagnosed by vaginal examination:

- Your doctor or midwife will use a speculum (an instrument used to separate the walls of the vagina) to see whether the cervix is changing in preparation for labour or has already opened up.
- Your doctor or midwife will also be able to see whether there is fluid leaking, which may indicate that your waters have broken. Sometimes the waters break before 37 weeks but labour doesn't

start. You can find out more about this from the RCOG patient information *When your waters break early: information for you*, which is available at: www.rcog.org.uk/womens-health/clinical-guidance/when-your-waters-break-early.

- A vaginal swab may be taken to check for infection.
- Another type of swab called fetal fibronectin may be taken from the top of the vagina, if you are at between 24 and 34 weeks of pregnancy. This test helps to see whether you are likely to go into labour soon or not:
    - Most women who are suspected of being in premature labour have a negative swab. This is very reassuring because fewer than one in 100 women with a negative test will go into labour within the next 2 weeks.
    - A positive swab means that there is an increased chance you may go into labour. One in five women who have a positive swab go into labour within 10 days.

  The swab will be less accurate if you have any bleeding, if your waters have broken or if you have had sexual intercourse in the previous 24 hours.

What happens if I am not in premature labour?

If labour is not confirmed or if you have a negative fetal fibronectin swab, you should be able to go home if you are well and there are no concerns for you or your baby.

What happens if I am thought to be in premature labour?

If labour is suspected, you will be advised to stay in hospital. You may be offered:

- a course of two to four corticosteroids injections usually over a 24–48 hour period to help with your baby's development and reduce the chance of problems caused by being born early (unless you have already received steroids in this pregnancy). You can find out more about this from the RCOG patient information *Corticosteroids in pregnancy to reduce complications from being born prematurely: information for you*, which is available at: www.rcog.org.uk/womens-health/clinical-guidance/corticosteroids.
- a course of antibiotics if it is confirmed that your waters have broken, to reduce the risk of an infection getting into the womb
- an opportunity to talk to one of the neonatal team about the care that your baby is likely to receive, if born early. You and your partner may also wish to visit the neonatal unit.
- medication (tablets or through a drip) to try to stop labour, if your waters have not broken and there are no concerns about you or your baby. This is only advised in the following circumstances:
    - while you are having your course of corticosteroids
    - if you need to be transferred to a hospital where there is a neonatal intensive care unit, which could be some distance away; this is particularly the case if you are less than 32 weeks pregnant.

  These medications are not routinely recommended for women having twins or triplets because it is not clear that they are beneficial in that situation.
- treatment with magnesium sulphate, through a drip in your arm. This would be considered if you are less than 30 weeks pregnant and likely to give birth within the next 24 hours. This treatment reduces the chance of complications for your baby, in particular cerebral palsy. You may experience minor side effects such as flushing and nausea. If you are advised to have this treatment, your doctor will discuss it fully with you.

Can premature labour be prevented?

In some circumstances, particularly if you have had a baby born prematurely or a late miscarriage in the past, you may be offered vaginal scans in pregnancy to measure the length of your cervix or you may be advised to have a suture (stitch) put around it to prevent it opening early. You can find out more about this from the RCOG patient information *Cervical suture: information for you*, which is available at: www.rcog.org.uk/womens-health/clinical-guidance/cervical-suture-0.

What if I don't go into labour?

You are likely to be able to go home. You should be offered a follow-up appointment with your midwife or a consultant depending on your individual circumstances.

If your waters have broken but you aren't in labour, you will be asked to return to the hospital for regular check-ups.

What about a future pregnancy?

Having your baby early means that you are at an increased risk of having a premature birth in a future pregnancy. However, you are still likely to have a baby born at more than 37 weeks next time.

You will be advised to be under the care of a consultant obstetrician who will discuss with you a plan for your pregnancy. This will depend on your individual situation and on whether a cause for your early delivery, such as infection, was found.

What to do if I have concerns or further questions

Talk to your midwife, who should be able to help. You can also ask to speak to your team of doctors and midwives at your maternity unit.

Making a choice

Shared Decision Making

If you are asked to make a choice, you may have lots of questions that you want to ask. You may also want to talk over your options with your family or friends. It can help to write a list of the questions you want answered and take it to your appointment.

Ask 3 Questions

To begin with, try to make sure you get the answers to three key questions if you are asked to make a choice about your healthcare.

1. What are my options?
2. What are the pros and cons of each option for me?
3. How do I get support to help me make a decision that is right for me?

These resources have been adapted with kind permission from the MAGIC Programme, supported by the Health Foundation

* Ask 3 Questions is based on Shepherd HL, et al. Three questions that patients can ask to improve the quality of information physicians give about treatment options: A cross-over trial. Patient Education and Counselling, 2011;84: 379-85

AQuA Advancing Quality Alliance · Right Care Shared Decision Making Programme · NHS

http://www.advancingqualityalliance.nhs.uk/SDM/

Sources and acknowledgements

This information has been developed by the RCOG Patient Information Committee. It is based on the following RCOG guidelines, RCOG scientific impact papers, journal articles and research studies, which contain a full list of the sources of evidence we have used:

Preterm Labour, Antibiotics, and Cerebral Palsy (Scientific Impact Paper No. 33), which is available at: www.rcog.org.uk/womens-health/clinical-guidance/preterm-labour-antibiotics-and-cerebral-palsy-scientific-impact-pape

Magnesium Sulphate to Prevent Cerebral Palsy following Preterm Birth (Scientific Impact Paper No. 29), which is available at: www.rcog.org.uk/womens-health/clinical-guidance/magnesium-sulphate-prevent-cerebral-palsy-following-preterm-birth-sa

Tocolysis for Women in Preterm Labour (Green-top Guideline No. 1b), which is available at: www.rcog.org.uk/womens-health/clinical-guidance/tocolytic-drugs-women-preterm-labour-green-top-1b

Preterm Prelabour Rupture of Membranes (Green-top Guideline No. 44), which is available at: www.rcog.org.uk/womens-health/clinical-guidance/preterm-prelabour-rupture-membranes-green-top-44

Prediction of premature labour with fetal fibronectin:

Peaceman AM, Andrews WW, Thorp JM, Cliver SP, Lukes A, Iams JD, et al. Fetal fibronectin as a predictor of preterm birth in patients with symptoms: a multicenter trial. *Am J Obstet Gynecol* 1997;177:13–18

Honest H, Bachmann LM, Gupta JK, Kleijnen J, Khan KS. Accuracy of cervicovaginal fetal fibronectin test in predicting risk of spontaneous preterm birth: systematic review. *BMJ* 2002;325(7359):301 (available at: www.ncbi.nlm.nih.gov/pmc/articles/PMC117763/)

Neonatal outcome data (EPICURE): www.epicure.ac.uk.

The RCOG produces guidelines as an educational aid to good clinical practice. They present recognised methods and techniques of clinical practice, based on published evidence, for consideration by obstetricians and gynaecologists and other relevant health professionals. This means that RCOG guidelines are unlike protocols or guidelines issued by employers, as they are not intended to be prescriptive directions defining a single course of management.

This leaflet was reviewed before publication by women attending clinics in Edinburgh, Birmingham, Newcastle upon Tyne and Warwick.

A glossary of all medical terms is available on the RCOG website at: www.rcog.org.uk/womens-health/patient-information/medical-terms-explained.

A final note

The Royal College of Obstetricians and Gynaecologists produces patient information for the public. The ultimate judgement regarding a particular clinical procedure or treatment plan must be made by the doctor or other attendant in the light of the clinical data presented and the diagnostic and treatment options available. Departure from the local prescriptive protocols or guidelines should be fully documented in the patient's case notes at the time the relevant decision is taken.

All RCOG guidelines are subject to review and both minor and major amendments on an ongoing basis. Please always visit www.rcog.org.uk for the most up-to-date version of this guideline.