this & that

01

OBSTETRIC QUICK GUIDES · IF THIS, THEN THAT

NO.



Preterm Labour

& cervical insufficiency

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Obstetrics & Gynaecology

Diagnosis & management

Verified against ACOG · SMFM · RCOG · SOGC — October 2026

Preterm labour & cervical insufficiency

At a glance: the numbers to remember

CL ≥30 mm	CL <20 mm	48 h	24^{+0}–33^{+6}	<32^{+0} wk
≤2% birth in 7 days → not PTL	>25% birth in 7 days → treat as PTL	the only realistic goal of tocolysis	core window: steroids & tocolysis	$MgSO_4$ neuroprotection (ACOG)

Where societies disagree, each position carries the society name; follow your local protocol. Doses are for singleton pregnancies unless stated.

01 Definitions

Source	Preterm labour (PTL) is…
ACOG PB 171 / Williams 26e	Regular contractions + cervical change (dilation and/or effacement), or regular contractions with ≥2 cm dilation at presentation, at 20^{+0}–36^{+6} wk.
Obstetric EBG 4e	≥4 contractions/20 min (or ≥8/h) at 20^{+0}–36^{+6} wk plus dilation ≥3 cm, TVUS CL <20 mm, or CL 20–29 mm with positive fFN. Contractions alone are called "threatened PTL".
NICE NG25	**Suspected** PTL = symptoms + intact membranes. **Diagnosed** PTL (≥30^{+0} wk) = suspected + CL ≤15 mm or fFN >50 ng/mL. **Established** = progressive dilation from 4 cm with regular contractions.

- Without cervical-length triage, 70–80% of women labelled "PTL" deliver at term and need no treatment.
- Symptoms are non-specific (cramps, pressure, backache, discharge, spotting); Braxton Hicks contractions are common. The diagnosis rests on cervical findings; contractions alone do not make it.

02 Triage & diagnosis

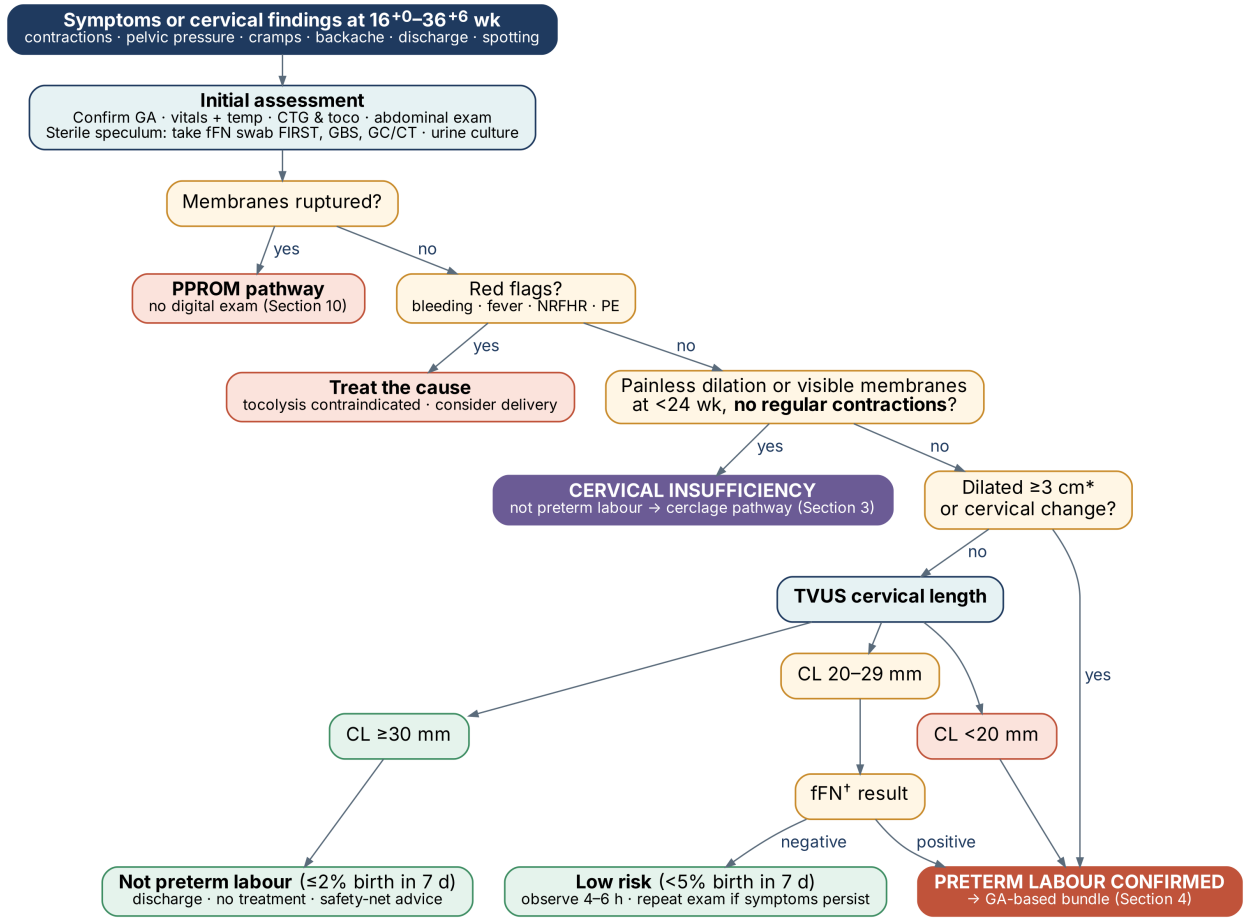


Figure 1. *Triage pathway: preterm labour, cervical insufficiency or neither.*

* ACOG threshold for dilation at presentation is ≥2 cm. fFN is valid at 22–34+6 wk with intact membranes, dilation <3 cm, no bleeding and no intercourse, digital exam or TVUS gel in the previous 24 h; positive = >50 ng/mL. Probabilities from Obstetric EBG 4e (singletons).

IF	THEN
Symptoms at 20+0–36+6 wk	• Confirm GA from best dating; check vitals and temperature • CTG + tocodynamometry; palpate for tenderness (abruption, infection) • Ultrasound: presentation, EFW, liquor, placental site
Vaginal bleeding	Exclude placenta praevia on ultrasound **before** any digital exam.
fFN might be needed	Take the swab **first** (posterior fornix, before digital exam, TVUS or lubricant); send only if CL turns out to be 20–29 mm.
Fluid leaking / pooling	Treat as PPROM → **no digital exam** → Section 10.
Membranes intact, cervix ≥3 cm (ACOG ≥2 cm) or documented change	**Preterm labour confirmed** → discard fFN swab → Section 4 bundle.
Cervix <3 cm, no change	TVUS cervical length (singletons). CL <20 mm = PTL; 20–29 mm = send fFN; ≥30 mm = not PTL.
CL 20–29 mm and fFN negative	<5% birth within 7 d → observe 4–6 h, repeat cervical check if contractions persist, then discharge.
CL ≥30 mm (any fFN)	≤2% birth in 7 d, >95% reach ≥35 wk → **no tocolysis, no steroids**; discharge with return advice.

IF	THEN
UK unit (NICE NG25)	• ≤29^{+6} wk: treat as PTL on clinical assessment • ≥30^{+0} wk: CL ≤15 mm = diagnosed PTL; >15 mm = unlikely • fFN only if TVUS unavailable; never use both together
Baseline tests in all	• Rectovaginal GBS culture (unless done in the last 5 wk) • Urinalysis + culture; gonorrhoea/chlamydia NAAT • Amniocentesis only if intra-amniotic infection is suspected; it is not routine

Biomarkers such as PAMG-1 and phIGFBP-1 (and the UK QUiPP app) may predict delivery better than fFN in symptomatic women, but no society yet recommends them in place of CL ± fFN.

03 Cervical insufficiency vs preterm labour

Cervical insufficiency is the inability of the cervix to retain a pregnancy in the second trimester **without contractions or labour** (ACOG). It is a structural failure of the cervix; preterm labour is the uterus contracting. The management is opposite: cerclage treats one and is contraindicated in the other.

	CERVICAL INSUFFICIENCY	PRETERM LABOUR
The problem	Weak cervix opens passively	Myometrium contracts and drives cervical change
Typical timing	Second trimester, mostly 16–24 wk	20^{+0}–36^{+6} wk
Contractions	Absent, or mild and irregular; **painless**	Regular and painful (≥4 per 20 min)
Presentation	Often silent: pressure, watery or mucoid discharge, spotting; found on speculum or scan	Cramps, backache, pelvic pressure, tightenings
Cervix	Dilated with little labour; membranes at or through the os ("hourglass")	Progressive dilation and effacement on serial checks
Typical history	Painless 2nd-trimester loss(es); cone/LEEP or cervical trauma; Müllerian anomaly; Ehlers–Danlos, Marfan; DES	Prior spontaneous PTB; infection; multiple pregnancy; polyhydramnios; bleeding
Main test	Speculum for dilation; TVUS CL 16–24 wk if prior sPTB	TVUS CL ± fFN to confirm or exclude
Treatment	**Cerclage** (± vaginal progesterone)	Steroids, $MgSO_4$, tocolysis ≤48 h, GBS cover; **no cerclage**
Tocolysis	Only peri-operative indomethacin around an exam-indicated cerclage	Short-term, to cover steroids or transfer

Bedside rule

- **Painless** dilation, no contractions, <24 wk → cervical insufficiency → ask whether a cerclage is possible.
- **Painful regular contractions** + cervical change → preterm labour → Section 4 bundle; cerclage contraindicated.
- Dilated **and** contracting before 24 wk → the process has become labour, infection or abruption: no cerclage; counsel; periviable care if ≥22 wk.
- About half of women with painless dilation ≥2 cm already have intra-amniotic infection, so look for it before a rescue cerclage (Obstetric EBG).

When to place a cerclage

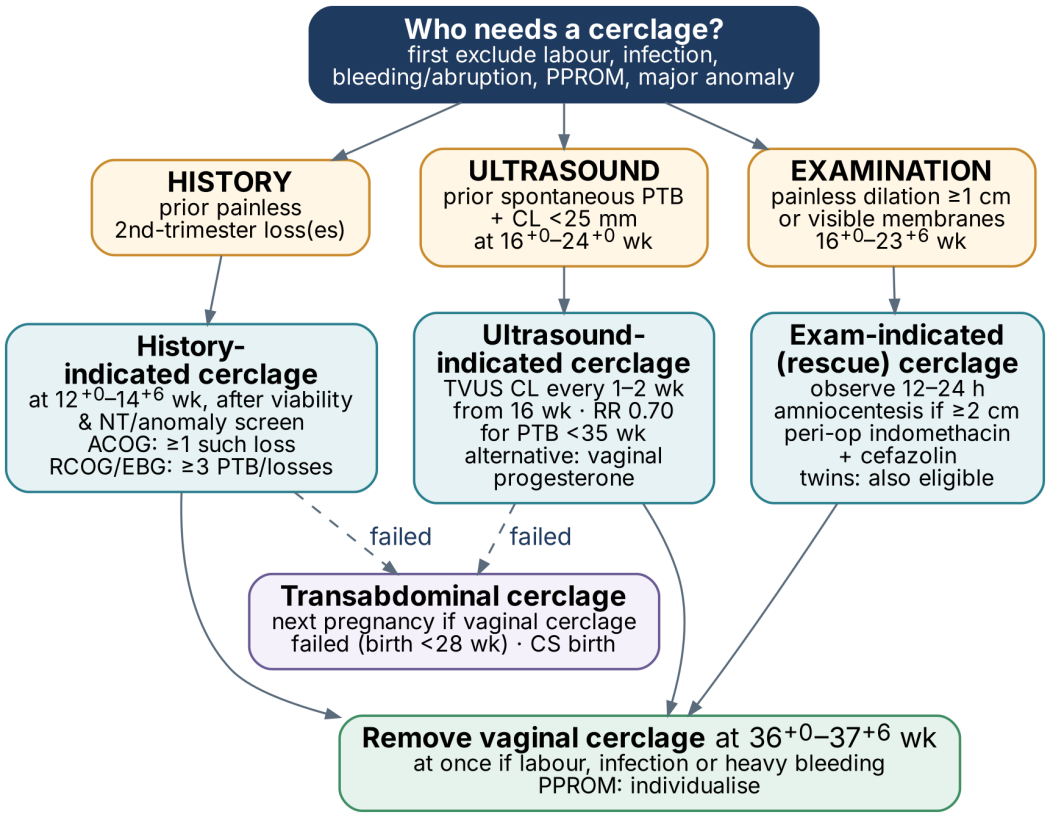


Figure 2. *The three indications for cerclage, and when to escalate to a transabdominal cerclage.*

IF	THEN
Prior painless 2nd-trimester loss(es), not due to labour or abruption	• **History-indicated cerclage** at 12^{+0}–14^{+6} wk, after a viability scan and aneuploidy/anomaly screening • ACOG: ≥1 such loss, or a prior cerclage for painless dilation • RCOG / Obstetric EBG: ≥3 previous PTBs or 2nd-trimester losses; fewer → serial CL instead
1–2 prior spontaneous PTBs, no classic history (singleton)	• Serial TVUS CL every 1–2 wk from 16^{+0} to 24^{+0} wk; this works as well as routine history-indicated cerclage • Progesterone on history alone: shared decision (SMFM); SOGC 2026: only if CL ≤25 mm
Prior sPTB + CL <25 mm at 16^{+0}–24^{+0} wk (singleton)	• **Ultrasound-indicated cerclage**: ↓ PTB <35 wk (RR 0.70) and ↓ perinatal morbidity/mortality • Vaginal progesterone is an acceptable alternative (ACOG 2026; NICE offers the choice) • RCOG/NICE threshold: CL ≤25 mm
Short cervix, no prior sPTB (singleton)	• CL ≤20 mm → vaginal progesterone 200 mg nightly to 36 wk (consider at 21–25 mm), per SMFM #70 • **No cerclage** for CL 10–25 mm without dilation (SMFM #70) • CL <10 mm → examine for dilation; if dilated → exam-indicated cerclage

IF	THEN
Painless dilation ≥1 cm or visible membranes at 16^{+0}–23^{+6} wk; no contractions, infection or bleeding	• **Exam-indicated (rescue) cerclage**: about 4 extra weeks of gestation and better neonatal survival • Observe 12–24 h first; consider amniocentesis (glucose, Gram stain, culture) if ≥2 cm or membranes prolapsing • Peri-operative indomethacin + cefazolin (↑ chance of ≥28 days' latency) • Window: ACOG ≤24^{+0}; NICE consider to 27^{+6}; RCOG rarely after 24 wk • Counsel: with bulging membranes only ~44% reach 28 wk (Williams)
Twins	• No history- or ultrasound-indicated cerclage (ACOG, RCOG, SMFM) • Exam-indicated cerclage for dilation <24 wk is recommended; in an RCT it lowered PTB <34 wk (RR 0.71) (ACOG 2026; Obstetric EBG)
Cone/LEEP, Müllerian anomaly, funnelling or prior PTB alone	Not indications on their own; screen with CL instead.
Previous vaginal cerclage failed (birth <28 wk)	• **Transabdominal cerclage** next pregnancy: pre-conception or 1st trimester; laparoscopic or open (SMFM #65) • MAVRIC trial: PTB <32 wk 8% vs 38% with a repeat vaginal cerclage • Requires caesarean birth; may be left for future pregnancies
Contractions, intra-amniotic infection, active bleeding/abruption, PPROM, IUFD or lethal anomaly	**Do not place a cerclage.** Manage as labour, infection or loss.

After a cerclage

IF	THEN
Uncomplicated course	• No routine antibiotics or tocolysis after history- or ultrasound-indicated cerclage • No serial CL after cerclage, no "reinforcing" second cerclage, no bed rest • Continue vaginal progesterone if already started
36^{+0}–37^{+6} wk	Remove the vaginal cerclage (McDonald: office procedure). Planned caesarean ≥39 wk: may remove at delivery (ACOG). A transabdominal cerclage stays in place; deliver by caesarean.
Labour, chorioamnionitis or heavy bleeding	Remove immediately to avoid cervical laceration and sepsis.
PPROM with cerclage in situ	• Individualise removal vs retention; remove if infection or labour • RCOG: removal may be deferred 48 h for steroids or transfer at 23–34 wk if no infection • If retained, do not extend latency antibiotics beyond 7 days (ACOG)

04 Management by gestational age

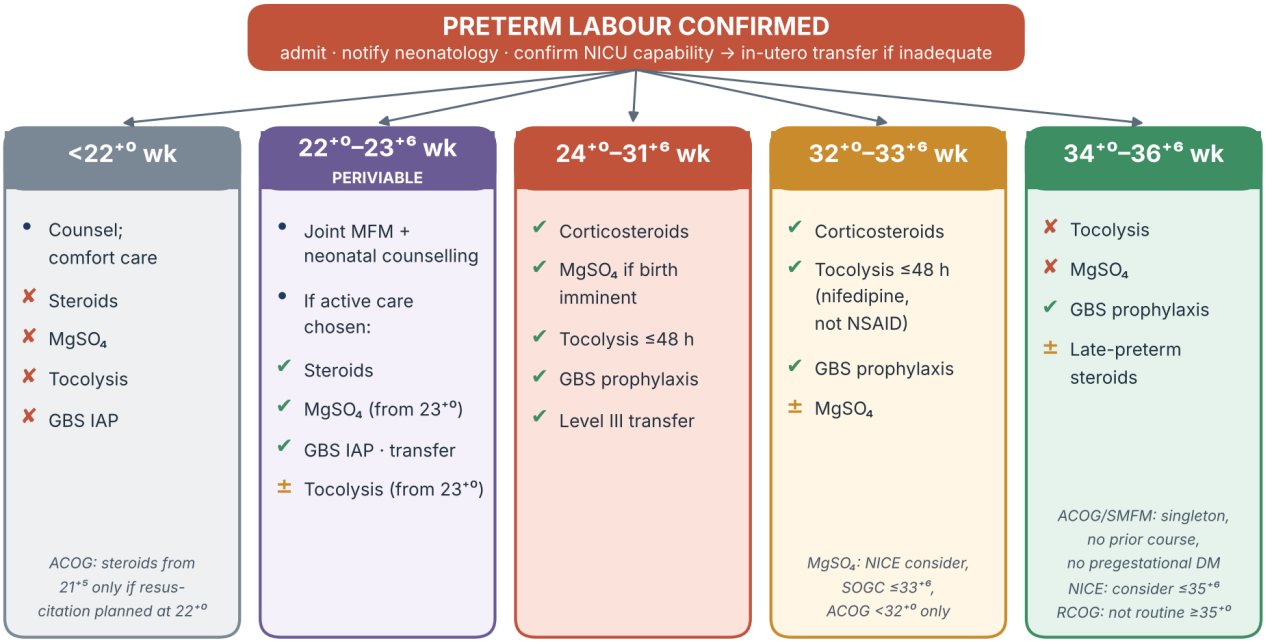


Figure 3. *What to give once preterm labour is confirmed, by gestational age band.*

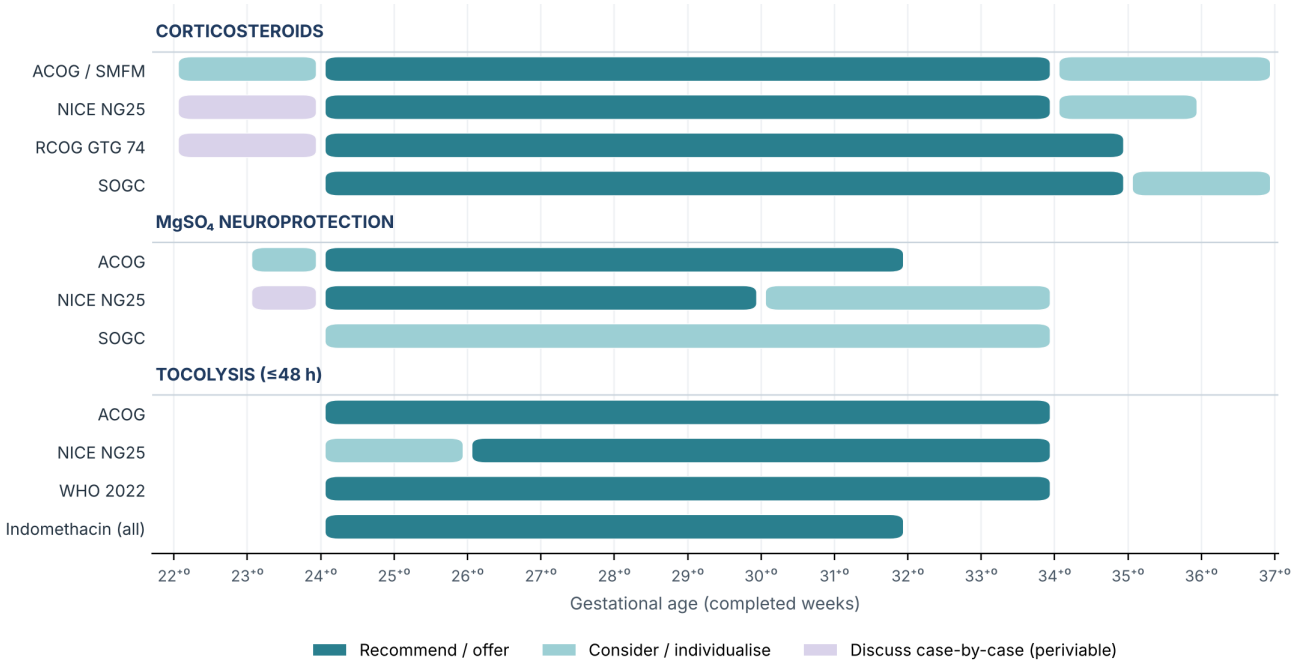


Figure 4. *Gestational-age windows for corticosteroids, $MgSO_4$ and tocolysis, by society.*

Universal steps once PTL is confirmed

- Admit; inform obstetric senior and neonatology (counselling at 22–34 wk).
- If the unit's NICU cannot care for a baby of this GA → in-utero transfer (tocolysis can buy the time).
- Give steroids, then $MgSO_4$ if birth is imminent and she is eligible, tocolysis only to cover these, and GBS prophylaxis.
- Continuous fetal monitoring while in active management; reassess cervix if contractions persist.

05 Antenatal corticosteroids

IF	THEN
24⁺⁰–33⁺⁶ wk and birth likely within 7 days	• **Betamethasone 12 mg IM ×2, 24 h apart** (or dexamethasone 6 mg IM 12-hourly ×4) • All societies agree (RCOG and SOGC extend to 34⁺⁶) • Includes twins and PPROM
Birth expected within 24 h	Still give the first dose, because partial courses help. **Never delay an indicated delivery** to complete it.
22⁺⁰–23⁺⁶ wk	• Give only if **active resuscitation is planned** after joint MFM–neonatal counselling • ACOG: may be considered from 22⁺⁰ (first dose from 21⁺⁵ if resuscitation planned at 22⁺⁰) • NICE/RCOG: discuss case-by-case
34⁺⁰–36⁺⁶ wk, singleton, no prior course, birth likely within 7 d	• **ACOG/SMFM:** betamethasone may be offered (ALPS) • **Not** in pregestational diabetes (SMFM) or chorioamnionitis • No tocolysis to complete the course; alert neonatal team (hypoglycaemia) • NICE: consider to 35⁺⁶ · RCOG: not routine ≥35⁺⁰ · SOGC: individualise after counselling
Prior course, still <34⁺⁰ wk, new high risk of birth	• One rescue course if ≥7 days since the first (ACOG prefers ≥14 days) • NICE: only if >7 days **and** birth very likely within 48 h • Maximum 2 courses in total; avoid serial weekly courses
Diabetes (any type)	Not a contraindication before 34 wk. Expect hyperglycaemia for ~5 days → intensify glucose monitoring and insulin by protocol.
Clinical chorioamnionitis	Deliver; do not postpone birth for steroids.

06 Magnesium sulphate for fetal neuroprotection

IF	THEN
<32⁺⁰ wk and birth imminent	• Active labour (≥4 cm), PPROM in labour, or planned birth within 24 h • ↓ cerebral palsy (RR ≈0.68; NNT ≈63; Cochrane, BEAM) • Give in singletons and twins; don't delay delivery to give it
Dose (choose one local protocol)	• **ACOG / BEAM:** 6 g IV over 20–30 min, then 2 g/h • **NICE / SOGC:** 4 g IV over 15–30 min, then 1 g/h, until birth or 24 h
Not delivered after 12 h and birth no longer imminent	Stop the infusion. If restarted >6 h later, give a new loading dose.
30⁺⁰–33⁺⁶ wk	NICE: consider (offer at 24⁺⁰–29⁺⁶). SOGC: consider up to 33⁺⁶. ACOG/Williams: not routine ≥32 wk.
23⁺⁰–23⁺⁶ wk	Only if active care chosen (NICE: discuss case-by-case).
On infusion	• Check RR, reflexes, urine output and SpO_2 at least 4-hourly • Renal impairment → reduce maintenance and check serum levels • Toxicity → stop; **calcium gluconate 1 g IV** over 10 min
Myasthenia gravis	Contraindicated.

IF	THEN
Already on $MgSO_4$ for pre-eclampsia	That infusion also covers neuroprotection; no extra dose is needed.

Do not use $MgSO_4$ as a tocolytic: no benefit over placebo, and >5–7 days of exposure risks fetal bone demineralisation (FDA).

07 Tocolysis

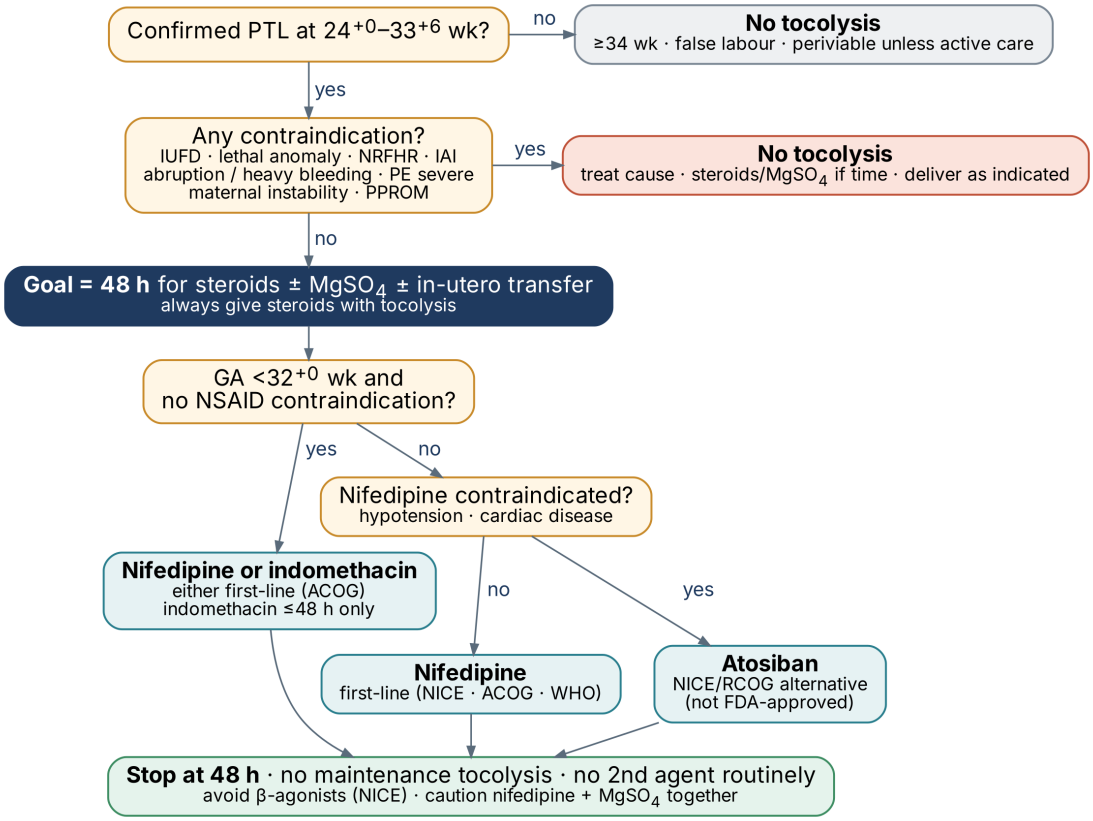


Figure 5. *Choosing (or withholding) a tocolytic.*

IF	THEN
Confirmed PTL at 24+0–33+6 wk, no contraindication	Short-term tocolysis (≤48 h), and only to complete steroids, give $MgSO_4$ or transfer. No tocolytic improves perinatal mortality.
Always	Give steroids alongside tocolysis. Tocolysis on its own has no proven neonatal benefit.
IUFD, lethal anomaly, NRFHR, chorioamnionitis, abruption/heavy bleeding, pre-eclampsia with severe features, maternal instability	**Do not tocolyse.** Treat the cause and deliver as indicated.
PPROM	Generally avoid (RCOG: not recommended; ACOG: insufficient evidence; EBG: no benefit, ↑ chorioamnionitis).
≥34+0 wk	No tocolysis, including to give late-preterm steroids.
Contractions settle after 48 h	Stop. **No maintenance tocolysis** (no benefit; oral nifedipine, terbutaline, $MgSO_4$ and indomethacin all fail).
First agent fails	Reassess the diagnosis (infection? abruption?). Routine second-line or combination tocolysis is not evidence-based.

Tocolytic agents

Agent	Regimen	Avoid if	Watch for
Nifedipine first-line	20 mg PO; if contractions persist, 10–20 mg every 20 min ×2; then 10–20 mg every 4–6 h to complete 48 h	BP <90/50, cardiac disease (aortic stenosis, LV dysfunction); caution with $MgSO_4$	Headache, flushing, hypotension, tachycardia
Indomethacin <32^{+0} wk only	50–100 mg PR/PO, then 25–50 mg every 6 h; **stop at 48 h**	≥32 wk, renal/hepatic disease, peptic ulcer, bleeding disorder/thrombocytopenia, NSAID-sensitive asthma, oligohydramnios	Ductal constriction and oligohydramnios if >48 h; scan liquor if prolonged (FDA NSAID warning)
Atosiban (UK/EU; not FDA-approved)	6.75 mg IV over 1 min, 18 mg/h for 3 h, then 6 mg/h; max 45 h	—	Few side effects; higher cost than nifedipine
Terbutaline not recommended	0.25 mg SC, for acute tachysystole only	Cardiac disease, arrhythmia, hyperthyroidism, diabetes; NICE: do not offer β-agonists	Tachycardia, hypokalaemia, hyperglycaemia, pulmonary oedema; FDA boxed warning

08 GBS prophylaxis & antibiotics

IF	THEN
PTL with GBS unknown or positive	• Start intrapartum prophylaxis and send culture (ACOG CO 797) • UK (RCOG GTG 36): offer IAP to all women in confirmed preterm labour
Labour stops	Stop antibiotics. Culture negative → no IAP if labour recurs within 5 wk. Positive → restart IAP when labour recurs.
Regimen	• Penicillin G 5 MU IV, then 2.5–3 MU every 4 h; or ampicillin 2 g, then 1 g every 4 h • Penicillin allergy, low anaphylaxis risk → cefazolin 2 g, then 1 g every 8 h • High risk → clindamycin 900 mg every 8 h (if susceptible) or vancomycin 20 mg/kg every 8 h
Intact membranes, no infection	**No antibiotics to prolong pregnancy.** In ORACLE II they gave no benefit and ↑ cerebral palsy at 7 years.
Fever / intra-amniotic infection	Broad-spectrum antibiotics (e.g. ampicillin + gentamicin), no tocolysis, expedite birth.

09 Special situations

IF	THEN
Twins	• Same steroid/$MgSO_4$ indications as singletons • CL vs birth within 7 d: >25 mm 0% · 21–25 mm 7% · 16–20 mm 21% · 11–15 mm 29% · 6–10 mm 46% · 1–5 mm 80% • Tocolyse cautiously: pulmonary oedema risk is higher • Deliver if ≥34 wk, PPROM, chorioamnionitis or non-reassuring testing
Pregestational diabetes	Steroids <34 wk with insulin adjustment; **no** late-preterm steroids (SMFM); avoid β-agonists.
Cardiac disease	Avoid β-agonists; nifedipine with caution → prefer atosiban, or indomethacin <32 wk.
Pre-eclampsia with severe features	No tocolysis. Seizure-prophylaxis $MgSO_4$ provides neuroprotection.

IF	THEN
Critically ill mother (ICU)	Generally do not suppress labour. It may be an adaptive response, and every tocolytic adds haemodynamic risk (MFM EBG).
FGR fetus	Steroids if birth expected within 7 d; $MgSO_4$ <32 wk; deliver in a unit with NICU.
Cerclage in situ and labour established	Remove the cerclage.
Periviable (22^{+0}–23^{+6})	• Counsel with local outcome data and parental values • Active care → steroids, $MgSO_4$ (from 23^{+0}), GBS IAP, CTG, transfer, tocolysis considered from 23^{+0} • Comfort care → none of these; no caesarean for fetal indication

10 If membranes have ruptured (PPROM)

IF	THEN
Suspected PPROM	Sterile speculum (pooling ± nitrazine/fern); PAMG-1/IGFBP-1 only alongside clinical assessment. **No digital exam.** Ultrasound for liquor.
Chorioamnionitis, abruption, NRFHR, cord prolapse or labour	Deliver (steroids, $MgSO_4$ and GBS IAP as GA allows).
<34^{+0} wk, stable	• Expectant management: steroids · $MgSO_4$ if <32 wk and birth imminent · GBS screen • **Latency antibiotics.** ACOG: ampicillin 2 g IV q6h + erythromycin 250 mg IV q6h ×48 h, then amoxicillin 250 mg PO q8h + erythromycin 333 mg PO q8h ×5 d (azithromycin 1 g PO once may replace erythromycin) • RCOG: erythromycin 250 mg QDS ×10 d or until labour · SOGC: macrolide-based (azithromycin) + GBS cover • No tocolysis; avoid co-amoxiclav (NEC)
34^{+0}–36^{+6} wk	ACOG: delivery recommended; expectant management to 37^{+0} is a reasonable alternative after counselling. RCOG: expectant to 37^{+0} if no contraindication.
<24 wk (previable / periviable)	Counsel on high maternal morbidity; offer expectant care **or** delivery (ACOG 2025 Practice Advisory, SMFM #71). No steroids or $MgSO_4$ until resuscitation would be offered.

11 After the episode & at birth

IF	THEN
Contractions stop, cervix unchanged after 4–6 h	• Discharge with return advice; review in 1–2 weeks • No maintenance tocolysis, bed rest, routine hydration, antibiotics or progestogen • Home care after steroids is as safe as staying in hospital
Labour progresses	• Continuous EFM preferred (Williams); NICE allows CTG or intermittent auscultation • Avoid fetal scalp electrode and fetal blood sampling <34^{+0} wk (NICE)

IF	THEN
Mode of birth	• Caesarean for usual obstetric indications only; it does not prevent IVH • Consider caesarean for breech at 26^{+0}–36^{+6} wk (NICE) • No routine episiotomy or "protective" forceps; avoid vacuum <34 wk (ACOG) / <32 wk (RCOG)
Baby born	• Delay cord clamping: ≥30–60 s (ACOG); ≥60 s with baby at or below the placenta (NICE) • Neonatal team present, resuscitation appropriate to GA

12 Do not

- Treat contractions alone with a long cervix (CL ≥30 mm).
- Give tocolysis without steroids, beyond 48 h, after 33^{+6} wk, or as maintenance.
- Use indomethacin ≥32 wk or for >48 h.
- Use β-agonists for tocolysis or $MgSO_4$ as a tocolytic.
- Give antibiotics to prolong pregnancy with intact membranes.
- Prescribe bed rest, IV hydration, home uterine monitoring, pessary or progesterone to treat arrested PTL or prevent its recurrence.
- Give more than 2 courses of steroids, or late-preterm steroids in pregestational diabetes.
- Place a cerclage in a contracting, infected or bleeding patient, or label painless dilation as preterm labour and miss the cerclage window.
- Offer cerclage for a short cervix alone (no prior sPTB, CL 10–25 mm), or history/ultrasound-indicated cerclage in twins.
- Use 17-OHPC (Makena); the FDA withdrew it in April 2023.

13 Where the guidelines differ

Topic	ACOG / SMFM (USA)	RCOG / NICE (UK)	SOGC (Canada)
Diagnosis	Contractions + cervical change or ≥2 cm; CL/fFN mainly to rule out	≤29^{+6} clinical; ≥30^{+0} CL ≤15 mm or fFN >50 ng/mL	—
Steroid window	Recommend 24^{+0}–33^{+6}; consider 22^{+0}–23^{+6}	Offer 24^{+0}–33^{+6} (RCOG to 34^{+6}); discuss 22–23^{+6}	24^{+0}–34^{+6}, within 7 d of birth
Late-preterm steroids	Offer 34^{+0}–36^{+6} (singleton, no prior course, not pregestational DM)	NICE consider to 35^{+6}; RCOG not routine ≥35^{+0}	Individualise after counselling (Technical Update 438)
Rescue course	Once, ≥7–14 d after first, <34 wk	Once, >7 d, birth likely within 48 h; max 2	—
$MgSO_4$	<32 wk; 6 g + 2 g/h (BEAM) or local protocol	Offer 24^{+0}–29^{+6}, consider to 33^{+6}; 4 g + 1 g/h ≤24 h	≤33^{+6}; 4 g + 1 g/h
Tocolysis	24–34 wk; nifedipine or indomethacin (<32 wk); 48 h	Nifedipine (offer 26^{+0}–33^{+6}); atosiban if contraindicated; no β-agonists	No current standalone guideline
GBS in PTL	IAP if status unknown/positive; stop if labour arrests	Offer IAP in confirmed preterm labour	IAP if unknown/positive
PPROM antibiotics	Ampicillin + erythromycin (or azithromycin) ×7 d	Erythromycin ×10 d	Macrolide (azithromycin) + GBS cover
PPROM delivery	≥34^{+0} (expectant to 37^{+0} acceptable)	Expectant to 37^{+0}	—
History-indicated cerclage	≥1 painless 2nd-trimester loss; 12^{+0}–14^{+6} wk	≥3 PTBs or 2nd-trimester losses	—
Exam-indicated cerclage	≤24^{+0} wk; twins eligible	NICE: consider 16^{+0}–27^{+6}; RCOG: rarely >24 wk	—

Topic	ACOG / SMFM (USA)	RCOG / NICE (UK)	SOGC (Canada)
Cerclage removal	36^{+0}–37^{+6} wk (up to 39^{+6} selected)	36^{+0}–37^{+0} wk	—

14 Sources

Textbooks

- Cunningham FG et al. Williams Obstetrics, 26th ed. Ch. 11 (cervical insufficiency, cerclage); Ch. 45 Preterm Birth (2022).
- Berghella V (ed). Obstetric Evidence Based Guidelines, 4th ed. Ch. 18 Preterm Birth Prevention (cerclage); Ch. 19 Preterm Labor; Ch. 20 PPROM.
- Berghella V (ed). Maternal-Fetal Evidence Based Guidelines, 4th ed. Multiple gestations; FGR; diabetes; critical care.

Guidelines checked (October 2026)

- ACOG Practice Bulletin 171, Management of Preterm Labor (2016); no replacement published as of Oct 2026.
- ACOG Committee Opinion 713, Antenatal Corticosteroid Therapy (2017, reaffirmed); ACOG/SMFM Practice Advisory, steroids at 22 weeks (2021).
- ACOG Committee Opinion 455, $MgSO_4$ for Neuroprotection (2010, reaffirmed 2023).
- ACOG Practice Bulletin 217, Prelabor Rupture of Membranes (2020); ACOG Practice Advisory on previable/periviable PPROM (2025).
- ACOG Committee Opinion 797, GBS Prevention (2020); ACOG Obstetric Care Consensus 6, Periviable Birth (2017).
- SMFM Consult Series #58, Late-preterm Steroids (2021, reaffirmed 2025); SMFM Consult #71, Previable/Periviable PPROM (2024); SMFM Statement on 17-OHPC (2023).
- NICE NG25, Preterm Labour and Birth (2015; updated 2019, 2022, 2024).
- RCOG Green-top 74, Antenatal Corticosteroids (2022); Green-top 73, PPROM (2019); Green-top 36, GBS (2017); BAPM Extreme Preterm Framework (2019).
- SOGC Guideline 364, Antenatal Corticosteroids (2018); Technical Update 438, Late-preterm Steroids (2023); Guideline 376, $MgSO_4$ (2019); Guideline 430, PPROM (2022).
- ACOG Clinical Practice Guideline 12, Obstetric Cerclage (Sept 2026; replaces PB 142). SMFM Consult #65, Transabdominal Cerclage (2023); #70, Short Cervix Without Prior sPTB (2024).
- RCOG Green-top 75, Cervical Cerclage (2022; review extended 2025). SOGC Guideline 373, Cervical Insufficiency and Cerclage (2019); Technical Update 467, Progesterone (2026).
- WHO Recommendations on Antenatal Corticosteroids and Tocolysis (2022). FDA NSAID safety communication (2020).

Decision aid only: it does not replace clinical judgement or local protocols. Verify drug doses against your formulary.