



# Risk of preterm birth

## Medication information table

	Eligibility	Regimen	Benefits	Considerations
ACS	<ul style="list-style-type: none"><li>GA – from viability to &lt;34<sup>+0</sup> confirmed by U/S.</li><li>Risk of preterm birth.</li><li>High likelihood of preterm birth in next 7 days.</li><li>No clinical evidence of maternal infection.</li><li>Adequate birth and preterm newborn care is available.</li></ul>	<ul style="list-style-type: none"><li>First course:<ul style="list-style-type: none"><li>dexamethasone 6 mg IM every 12 hours x 4 doses <b>or</b></li><li>betamethasone 12 mg IM every 24 hours x 2 doses.</li></ul></li><li>A single repeat course may be beneficial:<ul style="list-style-type: none"><li>only once, after 7 days of the first course and</li><li>only if all eligibility criteria are still met.</li></ul></li><li>More than two courses can be harmful to the fetus.</li></ul>	<p>Can reduce death in preterm babies by 22% by:</p> <ul style="list-style-type: none"><li>maturing fetal lungs</li><li>protecting fetal intestines and blood vessels in the brain.</li></ul>	<ul style="list-style-type: none"><li>Monitor blood glucose in women with pre-existing or gestational diabetes and expect an increased insulin need.</li><li>Might affect blood glucose levels in women with pre-existing or gestational diabetes.</li><li>Risks:<ul style="list-style-type: none"><li>maternal sepsis when used in women with chorioamnionitis or other infections</li><li>perinatal mortality in infants born at term.</li></ul></li></ul>
Nifedipine	<ul style="list-style-type: none"><li>GA – from viability to &lt;34<sup>+0</sup> confirmed by U/S.</li><li>High likelihood of preterm birth in next 7 days.</li><li>In preterm labour (based on skilled clinical assessment) with or without ruptured membranes.</li><li>The woman is receiving ACS.</li><li>No cardiac problems.</li><li>Not dangerous to prolong pregnancy.</li></ul>	<p><b>Modified/extended release nifedipine</b></p> <ul style="list-style-type: none"><li>Loading dose: 20 mg by mouth.</li><li>Maintenance 10–20 mg by mouth every 4–8 hours.</li><li>Never give more than:<ul style="list-style-type: none"><li>30 mg at one time, <b>or</b></li><li>60 mg/day.</li></ul></li></ul> <p><b>Immediate release nifedipine</b> Less available but preferred:</p> <ul style="list-style-type: none"><li>Loading dose: 20 mg by mouth</li><li>Repeat 20 mg by mouth every 20–30 minutes until contractions stop.</li><li>Maintenance 20–40 mg by mouth every 8 hours.</li><li>Never give more than:<ul style="list-style-type: none"><li>40 mg at one time, <b>or</b></li><li>160 mg/day.</li></ul></li></ul>	<p>Slows or stops contractions and can delay birth for ACS course and referral to be completed.</p>	<ul style="list-style-type: none"><li>Monitor the woman for an excessive drop in blood pressure and hold or reduce medication as needed.</li><li>Side effects:<ul style="list-style-type: none"><li>hypotension</li><li>tachycardia</li><li>palpitations</li><li>flushing</li><li>headache</li><li>dizziness</li><li>nausea.</li></ul></li><li>Risks: severe hypotension, shortness of breath.</li></ul>
Prophylactic antibiotics	<ul style="list-style-type: none"><li>GA – from viability to GA &lt;37<sup>+0</sup>.</li><li>Ruptured membranes (confirmed)</li><li>No known allergy to prescribed antibiotic.</li></ul>	<ul style="list-style-type: none"><li>Follow local protocols for the antibiotic.</li><li>Erythromycin: 250 mg by mouth four times/day for 10 days or until birth, whichever comes first.</li><li>If erythromycin is unavailable, use a penicillin such as amoxicillin.</li><li>Do not use co-amoxiclav/Augmentin due to increased rates of necrotizing enterocolitis.</li></ul>	<p>For PPROM, helps prevent infection, which also reduces prematurity-related problems for baby.</p>	<ul style="list-style-type: none"><li>Monitor closely and change to treatment protocol if signs of infection appear.</li><li>Side effects:<ul style="list-style-type: none"><li>diarrhea</li><li>nausea</li><li>vomiting</li></ul></li><li>Risks: allergic reaction.</li></ul>
MgSO4 (neuroprotection)	<ul style="list-style-type: none"><li>GA – from viability to &lt;32<sup>+0</sup> weeks confirmed by U/S.</li><li>In labour (≥5 cm) or planned birth within 24 h.</li><li>No cardiac problems or myasthenia gravis</li></ul>	<ul style="list-style-type: none"><li>Recommended IV options:<ul style="list-style-type: none"><li>4 g IV over 20 minutes,</li><li>then 1 g/h IV until birth or for 24 hours, whichever comes first.</li></ul></li><li>If IV is not possible:<ul style="list-style-type: none"><li>5 g MgSO4 50% solution IM in each buttock,</li><li>then 5 g MgSO4 50% solution every 4 hours alternating buttocks.</li></ul></li><li>Stop or delay maintenance dose if:<ul style="list-style-type: none"><li>patellar reflex absent</li><li>respirations less than 16 per minute</li><li>urine output less than 30 mL/h over the past 4 hours.</li></ul></li></ul>	<p>Given within 24 hours of preterm birth – reduces incidence and severity of cerebral palsy.</p> <p>Even one hour of exposure can have a positive impact.</p>	<ul style="list-style-type: none"><li>Can be used for severe pre-eclampsia or eclampsia to prevent seizures and has a mild tocolytic activity even though not recommended for this purpose.</li><li>If impaired renal function – loading dose only.</li><li>Side effects:<ul style="list-style-type: none"><li>sweating</li><li>flushing and feeling of warmth</li><li>headache</li><li>nausea/vomiting</li><li>slight decrease in fetal heart rate.</li></ul></li><li>Risks: respiratory or cardiac arrest related to magnesium toxicity (very rare).</li></ul>