HUTT maternity
Hutt Valley Maternity Care

HUTT VALLEY DHB

Document ID: MATY005	Version: 1.0
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Approved by: Maternity Quality Committee	Review date: July 2018

Borderline Viability, management of pregnancies

Hutt Maternity Policies provide guidance for the midwives and medical staff working in Hutt Maternity Services. Please discuss policies relevant to your care with your Lead Maternity Carer.

Purpose

To assist in the management of women who present with threatened labour or SRM before 24 weeks gestation

Scope

All maternity and paediatric personnel across the Hutt Valley DHB

Principles

These recommendations are based on the assumption that there is an accurate assessment of the gestation. In practise this may not be the case. In this situation the clinician's judgement will be influenced by the available history and an assessment of the infant at the time of delivery.

The gestation of possible viability is 23+0 weeks.

22+5 to 24 weeks

Obstetrician to discuss with Wellington hospital Obstetric team and NICU consultants regarding transfer from 23 weeks gestation. The Wellington NICU team would prefer *early transfer* to enable families to be counselled in detail about resuscitation and outcomes at such extreme prematurity.

If there is progression to spontaneous birth between 23 and 24 weeks, then being born in a tertiary centre will significantly improve baby's chance of survival and good outcome.

A clear plan for resuscitation is required. Discussion between the on-call obstetrician, paediatrician, MFM specialist, neonatologist and senior midwifery should include what level of care / resuscitation will be offered, and whether the neonatal team will attend the birth – if this is the case, the mother must be transferred to Wellington hospital.

Pregnancies at 22+5 weeks may be considered for steroids, tocolysis and transfer to Wellington after discussion with the Neonatologist, if resuscitation is planned from 23 weeks.

The plan needs to be carefully documented in the notes. In the case of very extreme prematurity and/or poor fetal condition, the parents should be given options that include palliative care for the baby.
Expectations for all staff and family should be *clearly documented.*
Once transfer is negotiated with obstetric and neonatal teams at CCDHB, the midwife looking after the mother needs to contact the ACMM of delivery suite at CCDHB to arrange a bed.

If there is no time to transfer, Hutt SCBU and Paediatric staff to be informed ASAP to allow as much preparation as possible. Wellington hospital NICU must be informed of the imminent delivery and likely need for transport team if resuscitation is successful.

If parents decide **against transfer and active treatment**, no attendance at the birth by Paediatric staff is necessary. They should be counselled about the possibility of baby showing signs of life at birth, and that if they change their mind regarding resuscitation the baby is very unlikely to do well being born at this gestation in a secondary unit.

A woman with ruptured membranes at <22+5 weeks can be managed as an outpatient; they are provided the contact details to MAU (including the 'direct access' card to MAU) and birthing suite (for after hours). They should be provided with the direct clinical access card for the birthing suite.

They are advised to

- check their temperature twice a day
- check for the colour of the liquor daily
- present to MAU/birthing suite if have high temperature(>37.3), feel unwell or if the liquor changes colour
- be seen in MAU twice a week for FHR, T, FBC and CRP

The woman should be discussed with Wellington Obstetric and NICU team from 22+5 weeks regarding antibiotics and steroids and transfer to Wellington Hospital for further management planning.

<u>Gestation 24+0 - 32+0 weeks</u>

- follow Preterm labour policy MAT056
- Antenatal steroids
- Commence tocolysis
- Magnesium sulphate administration should be given for Neuroprotection at <30 weeks gestation
- Antibiotics administration in active labour / PPROM
- CTG monitoring
- Discuss in-utero transfer to CCDHB and liaise with CCDHB Neonatal and Obstetric unit; Hutt Paediatrician on-call to be informed in case of issues around transfer.

Appendix

- Current outcomes at Wellington NICU (10 year data: 2002 - 12)

  23/40: 58% survival to discharge
  - 48% required home O2
  - 18% severe retinopathy of prematurity
  - 9% IVH grade 3 or 4

  24/40: 66% survival to discharge
  - 35% required home O2
  - 15% severe retinopathy of prematurity
  - 5% IVH grade 3 or 4

  Neurodevelopmental data pending.

Source: email correspondence with Dr Max Berry, NICU consultant, CCDHB

- NICHD Extremely Preterm Birth Outcomes Data
  https://www.nichd.nih.gov/about/org/der/branches/ppb/programs/epbo/pages/epbo_case.aspx

  Use the above on-line calculator to work out risk of death or neurodevelopmental disability depending on sex, birth weight, ante-natal steroids.

Informed Consent

The right of a consumer to make an informed choice and give informed consent, including the right to refuse medical treatment, is enshrined in law and in the Code of Health and Disability Consumers' Rights in New Zealand. This means that a woman can choose to decline treatment, referral to another practitioner, or transfer of clinical responsibility. If this occurs follow the process map on page 18 of the Referral Guidelines (Ministry of Health, 2012).