

Foreword

Together, March of Dimes California Chapter and Sutter Medical Center Sacramento have spearheaded the development of the following toolkit to augment the goals of the March of Dimes Prematurity Campaign. This toolkit was developed through a collaboration of health professionals in California, who took on the challenge of devising a clinical algorithm for the assessment and disposition of women presenting to any California hospital with signs and symptoms of preterm labor.

Numerous hospital protocols for preterm labor were collected and reviewed. In many cases, the assessment and disposition components were noted to be missing and it became clear that there was a desire among California Nurse Managers to establish consistent guidelines for assessment and disposition for preterm labor patients. With a large rural population, it was also imperative that the issues of patient safety, fetal wellbeing and transport to distant facilities be addressed in any guidelines produced by the task force. Consequently, practitioners from both urban and rural facilities were included in the task force membership. Throughout the process, the task force kept two questions in mind at all times: 1) Are the recommendations evidence based, and 2) Can this information be utilized effectively at all levels of facilities receiving these patients?

Perceptions of uterine contractions have always been interpreted by pregnant women as evidence for impending premature labor. The majority of these women will present to their local hospitals for assessment of labor, resulting in over half being admitted, treated and released without delivering after a few days. With the use of biochemical markers and sonographic evaluation of the cervix, it is possible to identify the majority of women who are not in preterm labor. Algorithm A is one of many that use rapid fetal fibronectin (fFN) in addition to uterine contractions in the diagnosis of preterm labor. This algorithm represents the results from practice information collected from representative hospitals in California as well as the review of reliable current research literature. It was specifically designed for use in rural and urban hospitals as a guide for treatment or transport decisions for patients who present with preterm labor symptoms.

Other facilities with access to high-risk pregnancy providers who can reliably determine cervical length by transvaginal ultrasound might utilize this modality to assist them in the evaluation of these patients. Algorithm B is for that subset of facilities which have regular access to reliable transvaginal ultrasound. Both algorithms provide the same outcome: determination of the optimal disposition of women who present with signs and symptoms of preterm labor.

Standardization of assessment and disposition of patients presenting with the signs and symptoms of preterm labor will 1) allow for timely interventions for preterm labor, 2) maintain maternal-fetal safety, 3) hospitalize only patients at greatest risk for preterm delivery, and 4) promote effective transport of preterm labor patients to higher, more appropriate levels of care.