TREATMENT APPROACH IN CASES OF THREATENED PRETERM LABOR

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Preterm labor (PTL) is defined as cervical change that develops in response to regular uterine contractions occurring between 20 0/7 and 36 6/7 weeks of estimated gestational age. The American College of Obstetricians and Gynecologists also states that PTL can be diagnosed in patients with regular contractions and cervical dilation of at least 2 cm before 37 weeks EGA, while the international guidelines from the World Association of Perinatal Medicine and the Perinatal Medicine Foundation recommend using a cutoff of at least 3 cm to diagnose spontaneous preterm labor [1]. Causes of PTL include decidual inflammation, decidual hemorrhage, pathologic uterine distention, and conditions that increase fetal and maternal stress. Risk factors for these underlying etiologies include the following: history of prior PTB, preterm prelabor rupture of membranes,shortened cervical length, intrauterine or vaginal infection, placental abruption, placenta previa, multifetal gestation, abnormally high or low amniotic fluid volume, conditions associated with uteroplacental insufficiency (eg, hypertensive disorders of pregnancy, diabetes mellitus, autoimmune disease), evidence of uteroplacental insufficiency (eg, fetal growth restriction, oligohydramnios, abnormal umbilical artery Doppler velocimetry), black race, extremes of maternal age (40 years or older), poor nutrition, low maternal body mass index, inadequate prenatal care, substance use [2-5]. In patients presenting with signs or symptoms of PTL, only 5.5% deliver within 1 week [6].

PTL is diagnosed by looking at the symptoms and checking the patient physically. According to ACOG (American College of Obstetricians and Gynecologists), PTL is usually diagnosed when a woman has **regular contractions** along with **changes in the cervix**, such as opening (dilation) or thinning (effacement), or when she first comes with regular contractions and her cervix is already opened at least 2 cm. There is no exact number for what counts as "regular contractions" in the ACOG definition, but different studies mention anywhere between 4 to 12 contractions per hour**.** A joint guideline by WAPM and PMF suggests defining regular contractions as 6 or more contractions in 30 minutes**.** They also recommend watching the patient for at least 2 hours to see how often contractions happen and whether the cervix changes during that time. Vital signs and abdominal/pelvic exams are essential. In stable patients**,** always perform the speculum exam before the digital exam to avoid altering test results and increasing infection risk (especially if membranes are ruptured). Abdominal exam**:** Contractions feel like tightening of the uterus. Tenderness may indicate infection or bleeding. Fetal weight and position can be estimated. Speculum exam**:** Assess cervical dilation, membrane status, bleeding, and discharge. Straw-colored fluid suggests membrane rupture. Bleeding may be from abruption or previa. Foul-smelling discharge suggests infection. Digital exam**:** Only after ruling out placenta previa and rupture. Checks cervical dilation, effacement, and fetal station. If cervix is ≥3 cm before 34 weeks, preterm birth is likely. Cardiotocographic monitoring**:** Tracks fetal heart rate and contractions. Confirms fetal well-being and whether symptoms match observed contractions. Beyond the history and examination, the evaluation of patients with threatened PTL includes collecting samples to test patients for ruptured membranes, urogenital infections, as well as transvaginal and limited obstetric ultrasounds. Membrane Status: Confirm rupture using speculum exam + tests (pH, microscopy, PAMG-1) if unclear. Group B Streptococcus (GBS): Rectovaginal culture needed unless tested in last 5 weeks or already positive. Urinalysis & Culture: Rule out UTI, which can mimic or trigger PTL.STI Testing: Screen for chlamydia, gonorrhea, syphilis if risk factors are present. Urine drug screen: Consider if placental abruption or substance use suspected [7]. Fetal fibronectin (fFN) is an extracellular matrix protein

localized at the decidual–chorionic interface. Disruption of this interface—due to subclinical infection, inflammation, placental abruption, increased proteolytic activity, or the mechanical effects of uterine contractions—can cause fFN to be released into cervicovaginal secretions, forming the basis for its use as a predictor of spontaneous preterm birth. We perform the fFN test selectively in patients who present with uterine contractions and a cervical length between 20–29 mm to help distinguish between true preterm labor and false labor. Relying solely on fFN results, without considering cervical length and other clinical findings, has not proven to be effective. A positive fFN test (≥50 ng/mL) indicates an increased risk of preterm birth, particularly within 7 days of testing. However, false-positive results can occur due to recent sexual intercourse, bloody samples, or recent digital cervical examinations. Currently, the production of the fFN test by Hologic has been discontinued in the United States. However, alternative methods are available in other countries. Quantitative fFN testing has shown improved predictive value and is more effective when combined with cervical length measurement. This approach is incorporated into clinical practice in some European countries through the use of the QUiPP app (Quantitative Instrument for the Prediction of Preterm Birth) [8,9].

Ultrasound Evaluation: 1) Transvaginal Ultrasound: Normal cervix: 35–48 mm. 2) Cervical length <25 mm high risk of PTL. 3) Cervical length ≥30 mm → <5% risk of PTL. Limited Obstetric Ultrasound:1) Assess amniotic fluid volume, fetal position, and estimated fetal weight; 2) Helps with delivery planning and neonatal care [10,11]. The assessment of preterm birth risk and triage criteria in twin pregnancies differs from singleton pregnancies due to the inherently higher baseline risk of preterm birth. As a result, the optimal cervical length threshold appears to be higher, although available data are limited. 1**)** At ≥34 weeks of gestation, triage is the same as for singleton pregnancies. 2) At <34 weeks of gestation in twin pregnancies with uterine contractions and intact membranes, the following triage approach is recommended: a) Cervical dilation ≥3 cm supports the diagnosis of preterm labor. In such cases, further evaluation with cervical length measurement or fetal fibronectin (fFN) testing does not add diagnostic value, and immediate treatment of preterm labor should be initiated. b) Cervical dilation <3 cm represents an uncertain diagnosis, and transvaginal ultrasound measurement of cervical length is indicated: 1) Cervical length >35 mm**:** If no cervical change occurs during a two-hour observation period and maternal and fetal conditions remain stable, the patient is considered at low risk of preterm birth and may be safely discharged home. 2) Cervical length <25 mm**:** Indicates a high risk of preterm birth, and appropriate interventions should be initiated to reduce neonatal morbidity associated with preterm delivery. 3) Cervical length 25–35 mm: fFN testing is performed. If the result is positive, interventions to reduce preterm birth-related morbidity are initiated. If the result is negative, the patient is observed for 6–12 hours and then discharged if no progression occurs. If fFN testing is not available, patients with cervical length between 25–35 mm can be managed similarly to those with cervical length >35 mm, but with a slightly extended observation period of approximately four hours [12,13].

Management strategies depend on gestational age and may include antenatal corticosteroids, tocolysis, magnesium sulfate, and group B Streptococcus prophylaxis to improve neonatal outcomes.

Corticosteroids: Treatment for preterm labor depends on how far along the pregnancy is. Doctors may give corticosteroids to help the baby's lungs develop. They also use medicines to stop contractions for about 48 hours, so the steroids have time to work. Magnesium sulfate is given to protect the baby's brain. Antibiotics are used to prevent infection from Group B Streptococcus. If the water breaks early, antibiotics are given for longer. It is important for patients in preterm labor to deliver in a hospital that can care for premature babies if needed. Antenatal corticosteroids help babies born early by improving their health. They work best if given 2 to 7 days before early birth. For this reason, these steroids are recommended for pregnant women at risk of early birth from about 22 weeks up to 34 weeks of pregnancy. Some medical groups suggest using them as early as 22 weeks if the baby will get special care after birth. After 34 weeks, different groups have different opinions about using these steroids. Different international organizations have made various rules about using antenatal corticosteroids based on research: 1) WAPM-PMF says treatment should be personalized and suggests giving steroids before 34 weeks of pregnancy. 2) SMFM advises talking to patients about the data and giving steroids to single babies between 34 and almost 37 weeks. But they don't recommend steroids for late preterm patients with diabetes because of the risk of low blood sugar in the baby. 3) ACOG agrees with SMFM and says steroids should not be

given if there is an infection inside the uterus. 4)NICE recommends thinking about steroids between 34 and almost 36 weeks. 5)RCOG suggests giving steroids up to almost 35 weeks. 6) SOGC says steroids can be considered between 34 and almost 37 weeks. 7) WHO recommends steroids from 24 to 34 weeks for many patients but advises against them if there is an infection or a planned C-section between 34 and almost 37 weeks. There are two ways to give antenatal corticosteroids:1) Two shots of betamethasone 12 mg, given by muscle injection 24 hours apart.2) Four shots of dexamethasone 6 mg, given by muscle injection every 12 hours. The ACOG and WHO say that if a person already had one course of steroids 7 to 14 days ago and still needs it, they can get one more "rescue" course. This rescue treatment can be either the usual 48-hour plan above or a single shot of betamethasone, which also works well after the first treatment [12-14].

Tocolysis: Tocolytic agents decrease the strength and frequency of uterine contractions, which may briefly prolong pregnancy. However, they do not treat the underlying causes of sPTL, have not been shown to delay birth until term, have not been shown to improve neonatal outcomes on their own, and are associated with a range of mild to severe adverse events. For these reasons, their use should be limited to a 48-hour course of treatment and reserved for patients who would benefit from a 48-hour delay in birth, such as patients who need the time for a course of corticosteroids to achieve maximal effect. Tocolytics are generally recommended for patients with threatened PTL between viability and 34 weeks EGA. In the periviable period, treatment with tocolytics should be individualized. In high-resource settings, experts recommend considering tocolysis down to 22 0/7 weeks EGA if neonatal resuscitation is planned. If contractions occur despite adequate tocolytic therapy, then the clinician must reassess the patient for amniotic infection, fetal compromise, possible abruption, and whether cervical dilation is progressing or the membranes have ruptured. Contraindications to tocolysis include preeclampsia with severe features, intraamniotic infection, antepartum hemorrhage, intrauterine fetal demise, lethal fetal anomaly, and significant maternal cardiac disease. Tocolytics are generally appropriate for patients with PPROM who lack evidence of maternal infection. The drug classes with the best evidence to support their use for tocolysis include calcium channel blockers (CCBs, typically nifedipine), cyclooxygenase (COX) inhibitors (typically indomethacin), and beta-agonists (typically terbutaline). Other tocolytic agents include oxytocin receptor antagonists (eg, atosiban), magnesium sulfate, and nitric oxide donors (eg, nitroglycerin). Combinations of tocolytics are generally not recommended [15].

1) Calcium channel blockers (CCBs) work by stopping the release of calcium inside muscle cells, which prevents the uterus from contracting. Nifedipine is a calcium channel blocker that is safer than other drugs used to stop labor and is often chosen for this purpose, especially after 30 to 32 weeks of pregnancy. Leading medical organizations like ACOG, WHO, NICE, and WAPM-PMF recommend nifedipine as the first choice for managing preterm labor from 24 up to 33 weeks of pregnancy. The usual way to give nifedipine is starting with a 20 mg oral dose, followed by 10 mg every 6 hours. CCBs do not cause serious problems for the fetus or newborn. However, because they widen blood vessels, side effects can include dizziness, fast heartbeat, nausea, and flushing. This treatment should not be used in patients with low blood pressure or certain heart conditions that depend on blood volume [16].

2) Cyclooxygenase inhibitors (COX inhibitors) stop the conversion of arachidonic acid into prostaglandins, which are chemicals that cause the uterus to contract. Indomethacin is often preferred by many experts for stopping preterm labor before 32 weeks of pregnancy because studies have shown it to be very effective and well tolerated. This may be because many cases of preterm labor are linked to inflammation or hidden infections. However, using COX inhibitors for more than 48 hours can cause problems such as narrowing of a fetal blood vessel called the ductus arteriosus and low amniotic fluid levels, especially in the third trimester. Studies have found that ductus arteriosus narrowing can start around 31 weeks of pregnancy and may affect about half of fetuses after treatment begins. Because of this risk, it is recommended to limit the use of indomethacin to certain patients and time periods. Long-term use of indomethacin in the second trimester shows fewer risks for ductal narrowing, happening in only a small number of cases. Some research has also linked indomethacin to serious newborn complications like brain bleeding, intestinal damage, and white matter injury, though it does not seem to increase other risks like lung problems or infections. These findings need careful interpretation because the studies varied in how indomethacin was used [17].

3) Beta-2 receptor agonists cause relaxation of smooth muscles, reducing contractions of the uterus.

However, uterine muscle cells become less sensitive to these drugs over time, which limits their effectiveness. Serious side effects are also more common with these agents. Although they are still used in some cases, beta-2 agonists are generally considered second-line tocolytics after COX inhibitors and calcium channel blockers because they are less effective and less safe. The NICE guidelines specifically advise against using these drugs for tocolysis. Importantly, beta-2 agonists increase the mother's heart rate, cause blood vessels to widen, relax the bronchi, and raise blood sugar levels. Because of this, these drugs are relatively contraindicated in patients with significant tachycardia, heart diseases sensitive to fast heart rates, and poorly controlled diabetes. Diabetic patients require close monitoring of their blood sugar and potassium levels and often need continuous insulin infusion if beta-2 agonists are used for tocolysis.

4) Oxytocin receptor antagonists are medications mainly used in Europe but not available in the United States. Atosiban is the most commonly used drug in this group and is recommended by the WAPM-PMF guidelines as a safe and effective first-choice alternative to nifedipine. A study involving 510 patients compared 48-hour treatments of oral nifedipine and intravenous atosiban in cases of threatened preterm labor and found no difference in the number of patients still pregnant after 48 hours or in overall newborn outcomes. Atosiban generally causes few side effects in mothers, mostly limited to reactions at the injection site, and has no major contraindications except for allergies to the drug.

5) Magnesium sulfate is effective at delaying spontaneous preterm birth (sPTB), similar to other tocolytic drugs. However, it is usually considered a second-line option because it has a higher risk of serious side effects for the mother. It is also used to reduce the risk of moderate to severe cerebral palsy in babies born before 32 weeks of pregnancy. Because of this, magnesium sulfate is often given early in preterm labor both to protect the baby's brain and to stop contractions. Although combining tocolytic drugs is generally not recommended, ACOG says a second tocolytic can be added if labor continues despite magnesium sulfate. In these cases, indomethacin is often the preferred choice. Calcium channel blockers (CCBs) and beta-2 agonists should not be used together with magnesium sulfate because together they can cause strong muscle relaxation and serious breathing problems.

6) **Nitric oxide donors:** Nitric oxide relaxes smooth muscles strongly, and nitroglycerin (a nitric oxide donor) has been tested to stop preterm labor. However, a 2014 Cochrane review found there is not enough evidence to recommend using nitric oxide donors routinely for treating threatened preterm labor.

Magnesium Sulfate for Neuroprotection: Magnesium sulfate provides neuroprotection: for newborns when given within 24 hours before early preterm birth (PTB). A 2024 Cochrane review confirmed that giving magnesium sulfate before delivery reduces the risk of cerebral palsy and likely decreases severe intraventricular hemorrhage (IVH) in babies born before 34 weeks of gestation. Guidelines worldwide vary slightly on when to use magnesium sulfate for neuroprotection. The WHO strongly recommends it for women at risk of PTB before 32 weeks. ACOG supports its use mainly before 32 weeks and encourages hospitals to create uniform guidelines. NICE suggests offering it between 24 and 29 weeks and considering it up to 33 weeks. WAPM-PMF recommends use up to 31 weeks, with possible use up to 33 weeks if the fetus is very small. Magnesium sulfate should not be used in patients with myasthenia gravis and should be used carefully in those with neuromuscular diseases or heart block. Since it is cleared by the kidneys, dosing adjustments are needed for patients with kidney problems to avoid toxicity. Patients receiving magnesium sulfate require close monitoring of vital signs, urine output, reflexes, and heart and lung function. In well-equipped settings, magnesium sulfate has not been shown to increase maternal death or serious heart and lung problems compared to placebo [1,12,17].

Group B Streptococcus (GBS) Prophylaxis: GBS prophylaxis should be given to all patients according to standard recommendations for its use. Preterm delivery is considered a risk factor for early-onset GBS disease and is an indication for prophylaxis in patients with unknown GBS status. RCOG recommends intrapartum GBS prophylaxis in all preterm patients. A clear association has been established between preterm labor (PTL) and genital tract infections. However, the evidence regarding the benefit of antibiotics as adjunctive therapy in PTL is inconsistent. While some studies have shown that antibiotics can prolong pregnancy, they have not consistently demonstrated reductions in maternal or neonatal morbidity. One possible reason is the low incidence of actual morbidity in study populations, which

limits the statistical power of these findings. There are also concerns regarding the potential risks of antibiotic use in this context. Unnecessary or poorly targeted antibiotic use can lead to bacterial resistance. Recent findings show that prenatal and intrapartum antibiotic use may increase the risk of antibiotic-resistant neonatal sepsis if infection occurs. Because of these concerns, the use of antibiotics solely to prolong pregnancy in women with PTL is not recommended. Instead, treatment should be reserved for clear clinical indications, such as group B streptococcus (GBS) prophylaxis, urinary tract infections, or other diagnosed infections. A major challenge in evaluating PTL is the difficulty in accurately diagnosing true labor. About half of the women presenting with preterm contractions ultimately deliver at term. Therefore, using antibiotics in all cases of idiopathic PTL may expose many women to unnecessary treatment. Biochemical markers like fetal fibronectin (FFN) may help identify women truly at risk. FFN testing, conducted in a large multicenter trial by Goldberg et al., showed that elevated FFN levels (>50 ng/mL) were associated with upper genital tract infections, clinical and histologic chorioamnionitis, and increased risk of neonatal sepsis. Peaceman et al. also demonstrated that a negative FFN result strongly predicted a low likelihood of delivery within 7 days (99.7% negative predictive value), suggesting FFN could be useful in identifying patients unlikely to benefit from antibiotics. Despite its potential, FFN screening is not currently recommended for routine use in this context, due to the lack of prospective trials proving its effectiveness.

The Role of Vaginal Progesterone in Preventing Preterm Birth in Women with a Short Cervix: Current evidence supports the use of vaginal progesterone in women identified with a short cervix to reduce the incidence of preterm birth and improve neonatal outcomes. Universal cervical length screening via transvaginal ultrasound during the midtrimester, followed by administration of vaginal progesterone in women with a short cervix, appears to be a cost-effective strategy, especially in nulliparous women. Vaginal progesterone treatment has been shown to reduce spontaneous preterm birth rates by approximately 45% and decrease neonatal morbidity. Importantly, these benefits are observed regardless of whether the woman has a prior history of preterm birth. While vaginal progesterone is effective in singleton pregnancies with a short cervix, its benefits in unselected twin gestations are less clear. However, subgroup analysis indicates that in twins with a sonographic cervical length under 25 mm, vaginal progesterone significantly reduces composite neonatal morbidity and mortality, with a favorable trend toward reducing preterm births before 33 weeks, although this trend did not reach statistical significance—likely due to limited sample sizes. For women with a history of preterm birth and a cervical length below 25 mm, treatment options include either vaginal progesterone or cervical cerclage, with evidence supporting the efficacy of both interventions. Implementing universal cervical length assessment combined with targeted progesterone therapy in women with a short cervix offers a practical and economically viable approach to preventing spontaneous preterm births [17].

PPROM is the rupture of fetal membranes before 37 weeks of gestation and is a leading cause of preterm birth. After membrane rupture, the risk of infection increases and labor often follows soon. Maternal infection can progress rapidly, so timely intervention is critical.

At term (≥37 weeks), immediate induction of labor after PROM leads to better outcomes, especially in GBS-positive cases. In preterm cases (<37 weeks), management depends on gestational age: Between 34-36 weeks, immediate delivery is recommended for GBS-positive patients; otherwise, expectant management with corticosteroids is advised. Between 24-33 weeks, expectant management with corticosteroids, latency antibiotics, and magnesium sulfate is recommended. Tocolytics may be used briefly. Before 24 weeks, survival chances are low, so the choice between termination and expectant management requires individualized consideration [14,17].

EGA (weeks)	Steroids	Tocolysis	Magnesium sulfate for neuroprotection	GBS Prophylaxis
22 to 31 6/7	Yes	IndomethacinNifedipineMagnesium sulfateTerbutaline	Yes	Yes, if GBS is unknown or known positive
32 to 33 6/7	Yes	Nifedipine or terbutaline	No	Yes, if GBS is unknown or known positive
34 to 36 6/7	Consider (guidelines vary)	None	No	Yes, if GBS is unknown or known positive

Intrapartum and Postpartum Care

During preterm labor, doctors usually use continuous cardiotocography to watch the mother and baby. Medicines like GBS antibiotics and magnesium sulfate for protecting the baby's brain should be given until the baby is born. After birth, waiting a bit before cutting the umbilical cord (called delayed cord clamping) helps premature babies. Waiting 30 to 60 seconds before clamping the cord is safe and helps increase the baby's blood volume, blood pressure, and red blood cells. This also lowers the need for blood transfusions and reduces death before leaving the hospital. But waiting too long, like 120 seconds, can cause problems like too many red blood cells and the need for longer light treatment.

Conclusion. Preterm labor remains a major cause of neonatal morbidity and mortality worldwide. Early identification of at-risk pregnancies through clinical history, cervical length screening, and biomarker testing is crucial for timely intervention. A multidisciplinary approach—guided by standardized protocols from ACOG, SMFM, WHO, RCOG, NICE, WAPM, and SOGC—enables effective prevention, diagnosis, and management. The use of antenatal corticosteroids, tocolytics, magnesium sulfate for neuroprotection, and appropriate referral to tertiary care centers significantly improves neonatal outcomes. Ongoing research and global collaboration are essential to further reduce the burden of preterm birth and enhance maternal-fetal care.

XÜLASƏ

Erkən doğuş təhlükəsi hallarında müalicə yanaşması

C.F. Qurbanova, N.A. Şahbazova, A.F. Əmirova, T.Ş. Əliyeva, F.F. Hüseynova, V.T. Səmədova, K.X. Əfəndiyeva
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***Açar sözlər**: Vaxtından əvvəl doğuş (VƏD), servikal uzunluq, fetal fibronektin (fFN), tokolitiklər, döl qişaların vaxtından əvvəl cırılması (DVƏC), çoxdöllü hamiləlik*

РЕЗЮМЕ

Тактика лечения при угрозе преждевременных родов

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***Ключевые слова:** преждевременные роды (ПР), длина шейки матки, фетальный фибронектин (ФФ), токолитики, преждевременный разрыв плодных оболочек (ПРПО), многоплодная беременность*

Vaxtından əvvəl doğuş (VƏD), hamiləliyin 20⁰⁄₇ və 36⁶⁄₇ həftələri arasında müntəzəm uşaqlıq yığılmalarının serviksin dəyişikliklərinə səbəb olması ilə xarakterizə olunur. Diaqnoz simptomlara, servikal dilatasiyaya (ACOG-a görə ≥2 sm; WAPM/PMF-yə görə ≥3 sm) və transvaginal ultrasəs və fetal fibronektin (fFN) testi kimi əlavə diaqnostik vasitələrə əsaslanır. Risk faktorlarına əvvəlki vaxtından əvvəl doğuş, qısa serviks, infeksiyalar, uteroplasentar çatışmazlıq, çoxdöllü hamiləlik, aşağı bədən kütlə indeksi (BMI), natamam antenatal qulluq və anada yanaşı xəstəliklər daxildir.Müalicə hamiləlik həftəsinə görə dəyişir və aşağıdakılardan ibarətdir: Antenatal kortikosteroidlər (34–36⁶⁄₇ həftəyə qədər) – dölün ağciyər yetkinliyi üçün verilir. Tokolitiklər (nifedipin, indometasin) – doğuşu qısamüddətli gecikdirmək və steroidlərin təsirini artırmaq üçün istifadə olunur. Maqnezium sulfat – 32 həftədən əvvəl dölün nevroproteksiyası üçün istifadə olunur. Qrupp B streptokok (GBS) profilaktikası – statusu məlum olmayan və ya pozitiv olan bütün PTL hallarında tətbiq edilir. Qısa serviksli qadınlara vaginal progesteron – vaxtından əvvəl doğuş riskini azaltmaq məqsədilə verilir. Vaxtından əvvəl membranların cırılması (PPROM) hallarında müalicə hamiləlik həftəsinə əsaslanaraq latentlik antibiotikləri**,** kortikosteroidlər **və** maqnezium sulfatı əhatə edir. 24–33 həftələr arasında infeksiya yoxdursa, gözləyici (expectant) yanaşma üstünlük təşkil edir. Doğuş zamanı qulluq davamlı döl monitorinqi, nevroprotektiv və antibiotik vasitələrin tətbiqi və göbək ciyəsinin 30–60 saniyə gecikdirilmiş kəsilməsini əhatə edir ki, bu da neonatal nəticələrin yaxşılaşdırılmasına kömək edir. PTL yükünü azaltmaq və ana-döl nəticələrini yaxşılaşdırmaq üçün ACOG, SMFM, WHO, NICE, RCOG, WAPM və SOGC kimi təşkilatların tövsiyələrinə əsaslanan çoxsahəli və protokollu yanaşma vacibdir.

Преждевременные роды (ПР) характеризуются регулярными сокращениями матки в период между 20⁰⁄₇ и 36⁶⁄₇ неделями беременности, вызывающими изменения шейки матки. Диагностика основывается на симптомах, раскрытии шейки матки (≥2 см по ACOG; ≥3 см по WAPM/PMF) и дополнительных диагностических инструментах, таких как трансвагинальное ультразвуковое исследование и тест на фетальный фибронектин (fFN). Факторы риска включают преждевременные роды в анамнезе, короткую шейку матки, инфекции, маточно-плацентарную недостаточность, многоплодную беременность, низкий индекс массы тела (ИМТ), неполное дородовое наблюдение и сопутствующие заболевания матери. Лечение варьируется в зависимости от гестационного возраста и включает следующее: Антенатальные кортикостероиды (до 34–36⁶⁄₇ недель) — назначаются для стимуляции созревания легких плода. Токолитики (нифедипин, индометацин) — используются для временной задержки родов и усиления эффекта стероидов. Сульфат магния — используется до 32 недель для нейропротекции плода. Профилактика стрептококка группы B (GBS) — назначается во всех случаях PTL с неизвестным или положительным статусом. Вагинальный прогестерон у женщин с короткой шейкой матки — для снижения риска преждевременных родов. В случаях преждевременного разрыва плодных оболочек (ПРПО) лечение включает латентные антибиотики, кортикостероиды и сульфат магния в зависимости от недели беременности. При отсутствии инфекции между 24 и 33 неделями предпочтительным является выжидательная тактика. Уход во время родов включает постоянный мониторинг плода, назначение нейропротекторов и антибиотиков, а также отсроченное пережатие пуповины на 30–60 секунд, что способствует улучшению неонатальных исходов. Междисциплинарный подход, основанный на протоколах и рекомендациях таких организаций, как ACOG, SMFM, ВОЗ, NICE, RCOG, WAPM и SOGC, имеет решающее значение для снижения бремени ПЖ и улучшения исходов для матери и плода.

ƏDƏBİYYAT

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