Preterm Prevention Clinic Information Leaflet / Treatment Options for short cervix (neck of womb)

This leaflet will provide you with some guidance and help in making a choice towards the best treatment option following a diagnosis of short cervix in the current pregnancy. This is based on the most recent evidence in this field.

What is the risk that preterm delivery would happen again in this pregnancy?

Women who have experienced either previous spontaneous preterm delivery (before 34 weeks) or previous late miscarriage (after 16 weeks) are at increased risk of preterm delivery. The chance that it will happen again increases with the number of prior preterm deliveries. With one prior spontaneous preterm delivery there is 2.5-fold increase in the risk of spontaneous preterm delivery in the current pregnancy over those with no prior spontaneous preterm delivery (20%, or 1in 5 chance). If this preterm delivery happens prior to 28 weeks there is a 3-fold increased risk of preterm delivery happening again and it is more likely to be before 28 weeks of gestation.

Prior preterm delivery caused by either preterm labour or you breaking your waters early (PPROM) carries a similar risk.

Women with two prior preterm deliveries have a risk of up to 42%, which increases to 60 % with 3 prior preterm deliveries for repeat preterm delivery in this pregnancy. If you have previously delivered after 37 weeks following a preterm delivery, then your risk of another preterm delivery is reduced.

What will be offered to me to reduce my risk of another preterm delivery?

If you have had a previous preterm delivery before 34 weeks either because you went into labour spontaneously or your waters broke early or if you had a previous late miscarriage (after 16 weeks), you would be offered a referral to a specialist clinic called the preterm prevention clinic (PPC). We have extensive experience of providing this service and PPC clinic has been running over a decade now.

All women attending the PPC clinic are offered vaginal swabs and testing for urine infection every 4 weeks; as infection in the vagina or the urine is the leading cause of preterm delivery and early detection and treatment may reduce the risk.

You will also be offered testing for checking the length of the neck of the womb (cervix) by an internal scan (Transvaginal ultrasound) from 14-16 weeks at regular intervals till 26 weeks and treatment would be offered if the length of the neck of the womb (cervix) is less than 25mm before 24 weeks; as these women are at increased risk of another preterm delivery.

By using ultrasound testing more than half of the women (58%) avoided needing any form of treatment as they never developed shortening of the neck of their womb (cervix).
In general, if cervix (neck of the womb) remains more than 25 mm long, there is a more than 90% chance that delivery will be after 34 weeks. See Image 1.

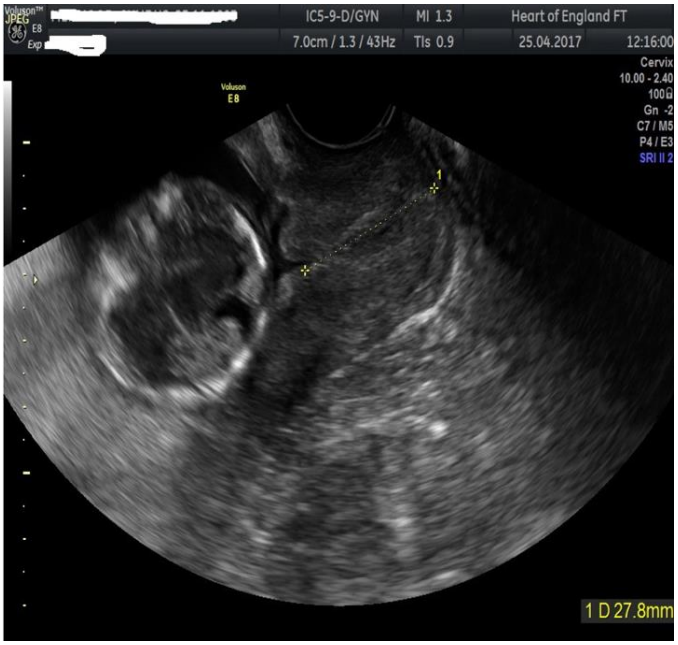


Image-1

Will I be offered a stitch on my cervix (neck of the womb) straight away/ without ultrasound testing?

A stitch on the neck of the womb (cerclage, suture) for preventing preterm delivery without ultrasound testing (screening) for shortening of the cervix (neck of the womb) is only offered to women with three or more previous preterm births and/ or late miscarriages (after 16 weeks).

One preterm delivery below 33 weeks gestation will be prevented for every 25 women who would have a stitch on the cervix in this group of women. This will normally be done after your dating scan and trisomy screening results as appropriate between 11- 14 weeks.

What treatment options would be offered to me if the length of the neck of my womb is less than 25 mm?

If the length of the neck of the womb (cervix) is below 25mm on an internal scan (transvaginal ultrasound) before 24 weeks, you would be offered the following options:

A] Do nothing (Expectant management)

B] Progesterone (pessary in the vagina)

Progesterone supplementation appears to reduce the rate of spontaneous singleton preterm birth in women who have had a previous spontaneous preterm singleton birth and in women with a short cervix on ultrasound examination in the current pregnancy.

Progesterone would be given in a form of vaginal pessary, if there is cervical shortening which would have to be taken daily till 34 weeks. It will be stopped if your membranes rupture or have significant bleeding at any point during the pregnancy.

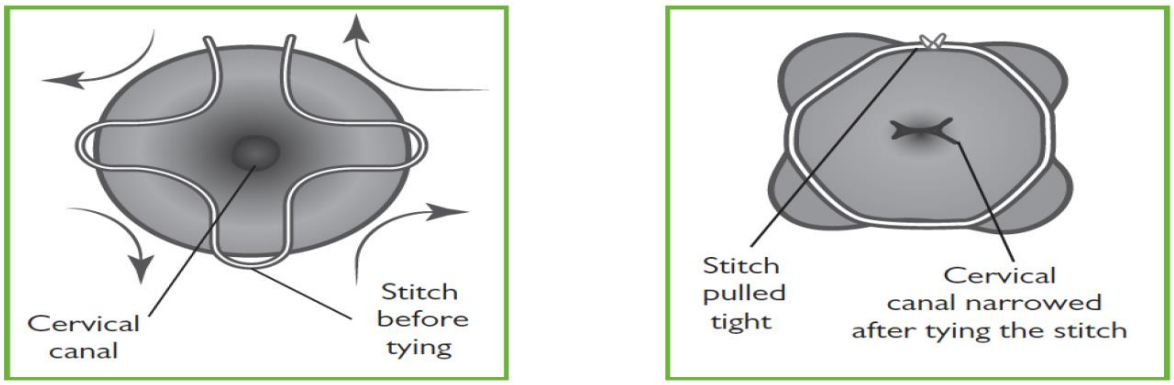
There are no known serious side-effects to the mother of using progesterone and no adverse effects so far are known to children born to women who took progesterone when pregnant.

C] Cervical Cerclage (stitch on the neck of the womb)

You will be offered a stitch on the neck of the womb (Image: Taken from RCOG leaflet on cervical stich) if your cervix (neck of the womb) progressively shortens and measures less than 25mm but is not fully open. This is done before 24 weeks and has been shown to reduce the risk of preterm delivery before 32 weeks by 25%.

In our experience, approximately one in five women coming to Preterm clinic requires cerclage. As per our own data over last eight years 85.3% of the patient who underwent cerclage delivered after 32 weeks and had good neonatal outcome (no significant morbidity). Approximately, 5.1% of the women had miscarriage i.e. delivered before 24 weeks in this group. 8.3% women delivered between 24-32 weeks.

The complications of cerclage include intra-operative complications such as bleeding, injury to the cervix, rupture of your bag of waters which are rare (less than 1%) and failure of suture to work. If you have the suture and your membranes rupture, we will need to remove the stitch due to increased risk of ascending infection.



The transvaginal cervical stitch procedure (left) and once it is completed (right)

Is progesterone better than stitch?

There are no studies comparing progesterone with stitch on the cervix, however a recent study has done an indirect comparison of the two. The key finding of this study is that vaginal progesterone and cervical cerclage have similar efficacy (or are no different) for the reduction of risk of preterm birth and for the adverse outcomes for the baby in women with a short cervix and a history of preterm birth.

Will I be offered a stitch if the neck of my womb is open (rescue suture)?

There are no good quality studies to show benefit of putting a stitch on the neck of the womb when it is open and the bag of waters is exposed. However, it has been shown to be

beneficial in some small studies. As per our own data, 19 out of 30 (63%) women who had rescue cerclage successfully continued their pregnancy beyond 32 weeks and only five women had pregnancy loss before 24 weeks.

Insertion of a stitch when the neck of your womb is open and bag of waters exposed may delay delivery by a further 5 weeks on average compared with doing nothing.

The decision to place a rescue suture should be discussed with your consultant and would depend on the dilatation of the neck of your womb and your stage in pregnancy (gestation); as even with rescue cerclage the risks of very early preterm delivery and risks to your baby remain high.

There is 50% chance of rupture of membranes at time of surgery or soon after, if this happens it further increases the chance of miscarriage or early preterm delivery and the outcome becomes similar to or worse than expectant management (doing nothing). Advanced dilatation of the cervix (more than 4 cm) or membrane prolapse beyond the neck of the womb into the vagina appears to be associated with a very high chance of cerclage (stitch) failure. Rescue cerclage is rarely justified after 24 weeks.

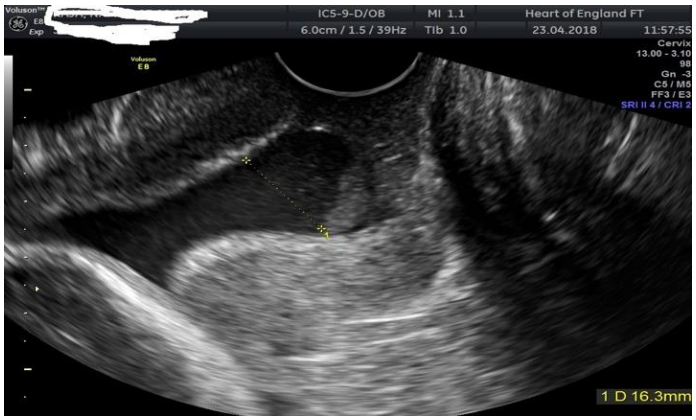


Image 2

Are there situations when a cervical stitch would not be advised?

Sometimes a cervical stitch is not advised because it may carry risks to you and it would not improve the outcome for your baby. This may be if:

- you have any signs of infection
- you are having vaginal bleeding
- you are having contractions
- your waters have already broken.

If you are pregnant with more than one baby, there is little evidence to show that a cervical stitch will prevent you going into labour early and your care will be individualised depending on your situation via the Twin Clinic.

What should I expect afterwards?

After the operation, you may have some vaginal bleeding or brownish discharge for a day or two. You should not feel any significant discomfort from the stitch. The plan of care for you

and your baby will be discussed with you. Having a stitch in place will not affect your baby's growth and development.

Is there anything I should look out for?

You should contact Labour Ward if you experience any of the following:

- Contractions or cramping abdominal pain
- Continued or heavy vaginal bleeding
- your waters breaking
- smelly or green vaginal discharge.

How and when will the stitch be taken out?

Your stitch will be taken out at the hospital. This will normally happen at around 36–37 weeks of pregnancy, unless you go into labour before then. If you are having a planned caesarean, the stitch can be taken out at the time of the operation.

A speculum is inserted into your vagina and the stitch is cut and removed. You will not normally need anaesthetic for removal of the stitch but occasionally you will be advised by your healthcare professional that this is necessary. It usually takes just a few minutes and you may experience some discomfort.

Most women do not go into labour immediately after their stitch is removed. If you go into labour with the cervical stitch still in place, you should contact your maternity unit straight away. It is important to have the stitch removed to prevent damage to your cervix. If your waters break early but you are not in labour, the stitch will usually be removed because of the increased risk of infection. The timing of this will depend on your individual situation.

Further support:

https://www.rcog.org.uk/media/biim1pwk/cervical-stitchpi_final_amended.pdf
www.tommys.org

You can contact Tracey Ashford and Ann Horne PPC midwife Heartlands hospital via 01214240730