MATERNITY GUIDELINES

Cervical scanning and cerclage guideline for singleton pregnancies

(Excluding patients who conceived via assisted conception or patients of the recurrent miscarriage clinic)

Contents

1. Background

Preterm delivery, defined as the birth of an infant before 37 completed weeks of gestation, is the single most important determinant of neonatal morbidity and mortality[1]. The majority of prematurity-related adverse outcomes relate to birth before 33+0 weeks of gestation, with mortality rates increasing from approximately 2% at 32 weeks, to more than 90% at 23 weeks of gestation[2].

Assessment and planning of care for these women to prevent neonatal morbidity and mortality should be optimised if at all possible.

2. Assessment and care plan

All women with a history of a previous suture, spontaneous preterm births less than 34 weeks and/or second-trimester losses should be referred to a Consultant led antenatal clinic for a review to coincide with their booking scan if possible.

Referral to the preterm labour clinic should occur for the following indications:

1. Previous delivery less than 34 weeks
2. Previous late miscarriage (not fetal demise prior to labour)
3. Previous PPROM <34 weeks
4. Previous cervical cerclage
5. Known uterine variant (eg bicornuate / unicornuate uterus, septa etc)
6. Previous 2xLLETZ
7. Previous LLETZ of 15mm or over
8. Previous cone biopsy
9. Previous trachelectomy (although often seen by units in London)

Women should be referred from blue box review, and first review should take place between 12 and 14 weeks gestation.

3. Cervical length screening

This should be performed for the appropriate women at two weekly intervals (dependent upon history).

If a cervix is measured at <25mm, having been seen to shorten, or in a women with significant history of preterm delivery, cervical cerclage should be offered.

The use of fetal fibronectin (in combination with the QUIPP app) can also assist in the risk stratification of women. In the absence of a fetal fibronectin this can be used with cervical length alone, however risk stratification is more accurate with the use of quantitative fibronectin.

Cervical length screening should be performed by an appropriately trained individual.

4. Rescue cervical cerclage

This decision should be individualised, taking into account the gestation at presentation of premature cervical dilatation.

This should not take place in the presence of any indication of active labour, bleeding or SRM.

5. Cervical cerclage insertion

- Book on the elective LSCS list (last case)
- Ensure the doctor leading this operating list is made aware beforehand so that they can agree to the procedure and they have the competency to perform the procedure.
- The choice of suture material remains individual choice, this includes:
    - Mersilene tape, nylon or Prolene non-absorbable monofilament suture (look in gynaecology theatre if not available in maternity)
- Knots are conventionally tied anteriorly to the cervix with a loop.
- Draw a diagram in the operation record and green antenatal notes to clearly describe the technique used.
- Operation notes should be photocopied in the event of in-utero transfer to other Obstetric providers.
- Registrars to perform cervical cerclage insertion **only** under direct Consultant supervision, unless they have completed the relevant eportfolio competences.

6. Abdominal Cerclage

- Abdominal cerclage should only be discussed with patients who have had a failed previous cervical cerclage.
- Patients who may be suitable should be counselled by two consultants with recognised knowledge and experience of the procedure.
- The procedure may be offered as an interval process between pregnancies, but can also be offered during a pregnancy after 14 weeks and up to 20 weeks.

7. Cervical cerclage removal

A cerclage should be removed if:

1. There are active signs of labour
2. There is active bleeding
3. There is rupture of membranes
4. There is cervical dilation observed on speculum / VE
5. The pregnancy has reached 37 weeks gestation
6. Induction of labour is required for any other reason

Note: abdominal cerclage is not removed.

8. Progesterone

There is no evidence of benefit to the use of progesterone outside of luteal support. It should not be offered.

9. Record Keeping and documentation

It is expected that every episode of care be recorded clearly, in chronological order and as contemporaneously as possible by all healthcare professionals as per Hospital Trust Policy. This is in keeping with standards set by professional colleges, i.e. NMC and RCOG.
All entries must have the **date and time** together with **signature and printed name**.

Monitoring and Audit

Auditable standards:
Assessment prior to commencement of cervical measurement
Assessment prior to commencement of insertion of suture
Assessment of gestational duration

Please refer to audit tool, location: 'Maternity on cl2-file11', Guidelines

Reports to:
Clinical Effectiveness Committee – responsible for action plan and implementation of recommendations from audit

Frequency of audit:
5 years

Responsible person:
Fetal medicine lead

Cross references

Guidelines can now be found on the network share (drive) 'G:\DocumentLibrary\UHPT Clinical Guidelines\Maternity'.

Maternity Hand Held Notes, Hospital Records and Record Keeping

Guideline development within the maternity services

Medicines Management Policy

References

1. NICE guideline 25, Preterm Labour and Birth (update 2019)m
2. Alfirevic Z, Stampalija T, Medley N. Cervical stitch (cerclage) for preventing preterm birth in singleton pregnancy. Cochrane Database of Systematic Reviews 2017, Issue 6.
3. Norman, J. E., Marlow, N., Messow, C. M., Shennan, A., Bennett, P. R., Thornton, S., … OPPTIMUM study group (2016). Vaginal progesterone prophylaxis for preterm birth (the OPPTIMUM study): a multicentre, randomised, double-blind trial. *Lancet (London, England)*, *387*(10033), 2106–2116. doi:10.1016/S0140-6736(16)00350-0
4. Norman JE, Bennett P (2017) Preterm birth prevention—Time to PROGRESS beyond progesterone. PLoS Med 14(9): e1002391. https://doi.org/10.1371/journal.pmed.1002391
5. Cook JR, Chatfield S, Chandiramani M, et al. Cerclage position, cervical length and preterm delivery in women undergoing ultrasound indicated cervical cerclage: A retrospective cohort study. *PLoS One*. 2017;12(6):e0178072. Published 2017 Jun 1. doi:10.1371/journal.pone.0178072

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Version	2		
Changes	Indications for screening Timing of initial medial consultation in preterm labour clinic Removal of progesterone as a treatment for those at high risk of preterm labour Indications for removal of cerclage Timing of cervical assessments Who should perform cervical assessments		
Date Ratified	March 2020	**Valid Until Date**	March 2025