Preterm infant feeding and growth monitoring: Implementation of the INTERGROWTH-21st protocol

Module 1
Background on preterm birth
On successful completion of this module you should be able to:

- Define the different categories of preterm delivery and low birth weight.
- Know the global burden of preterm deliveries and calculate preterm birth rates.
- Identify the risk factors for preterm delivery.
- List the long-term effects of preterm deliveries.
- State the global goals for reduction of preterm deaths and the 2025 Global Nutrition targets.
- Know the different methods for gestational age estimation and their strengths and limitations.
- Assess gestational age from crown-rump length and symphysis-fundal height measurements using the respective INTERGROWTH-21st international standards.
- Conduct an anthropometric assessment of the newborn preterm.
- Use the INTERGROWTH-21st postnatal growth standards for preterm infants and INTERGROWTH-21st Newborn Size Application Tool.
- Know the WHO recommendations on the following interventions for preterm deliveries: Kangaroo mother care, continuous positive airway pressure, surfactant administration, oxygen therapy, antenatal corticosteroids administration, tocolysis for inhibiting preterm labour and magnesium sulfate administration.
**Introduction**

Preterm delivery is a public health concern of global magnitude with 15 million preterm babies born annually. It is the leading cause of neonatal mortality and second cause of mortality in children below 5 years (Howson CP, 2013; Liu L, 2016).

Premature interruption of maternal transfer of macro and micronutrients coupled with inability to produce the necessary amount of metabolically essential forms of key nutrients such as Docosahexaenoic acid (DHA) and arachidonic acid by the premature infant poses a development challenge. As such, most preterm infants do not achieve a growth trajectory similar to the last intrauterine trimester (Raiten DJ, 2016).

Moreover, while preterm postnatal growth has been portrayed in many growth charts to mimic that of infants who grow to term, assuming a convex curve with late flattening of “growth”, the Preterm Postnatal Follow-up Study of the INTERGROWTH-21st Project established that postnatal growth in preterm infants assumes an upward curve instead, up to 42 weeks’ gestation (see animation below in the next slide) (Villar J, 2015).


Click to play infographic on how growth trajectories differ between preterm infants (blue) and fetuses who grow to term (red) matched for gestational age, in both boys and girls.
Introduction

The difference in growth trajectories noted in the preceding charts between postnatal preterm babies and foetuses growing to term in the Preterm Postnatal Follow-up Study (PPFS) of the INTERGROWTH-21st Project, as compared to previous charts, emanates from the fact that previous studies used in creating preterm postnatal growth standards were noted to have several inconsistencies, which could have compromised the quality.

For example, studies previously used to derive preterm postnatal growth charts were noted to have shortcomings regarding anthropometric assessments, estimation of gestational age, duration of follow-up, reporting of postnatal care and morbidity, assessment of outliers and covariates, and the presentation of charts.

The PPFS, however, used a prescriptive approach, longitudinally following healthy, well nourished preterm infants free from environmental and socioeconomic constraints on growth, in eight centres across the globe. This approach implies that the INTERGROWTH-21(st) growth standards are generalisable to other populations irrespective of ethnic and geographical differences.

Introduction

While more interventional studies are needed, current evidence (especially from observational studies) suggests that an accelerated growth between preterm and term-corrected age is beneficial to long-term neurodevelopment, although this also poses a metabolic risk later in life given that most of the catch-up growth is composed of increase in body fat (Ong KK, 2015; Belfort MB, 2013).

Nutritional needs of preterm infants therefore exceed those of healthy term infants in the sense that extra care is needed to optimize growth while at the same time avoiding the risks of undernutrition and overnutrition both in early and later life.

In summary, early postnatal growth in all neonates including preterm babies should be as physiological as possible for optimum survival and long-term outcomes (Villar J 2015).

These three modules focus on preterm birth and on preterm infant feeding modalities to ensure optimum growth based on existing evidence, as well as monitoring of this growth.
Definitions

Consistent definitions to describe the length of gestation and age in neonates are necessary to promote accurate interpretation of data on neurodevelopmental, medical, and growth outcomes as well as allowing comparisons, especially for those born preterm or conceived using assisted reproductive technology. To avoid confusion, you will find the following definitions useful:

<table>
<thead>
<tr>
<th>Term</th>
<th>Definition</th>
<th>Units of time</th>
</tr>
</thead>
<tbody>
<tr>
<td>Gestational age</td>
<td>Time elapsed between the first day of the last menstrual period and the day of delivery. If pregnancy was achieved using assisted reproductive technology, gestational age is calculated by adding 2 weeks to the conceptional age.</td>
<td>Completed weeks</td>
</tr>
<tr>
<td>Chronological age</td>
<td>Time elapsed since birth</td>
<td>Days, weeks, months, years</td>
</tr>
<tr>
<td>Postmenstrual age</td>
<td>Gestational age + chronological age</td>
<td>Weeks</td>
</tr>
<tr>
<td>Corrected age</td>
<td>Chronological age reduced by the number of weeks born before 40 weeks’ gestation</td>
<td>Weeks, months</td>
</tr>
</tbody>
</table>

Definitions

**Preterm delivery** is defined as all births before gestational age of **37 weeks or fewer than 259 days** since the first day of a woman’s last menstrual period. Gestational age at birth forms the basis of sub-categories as follows:

- Extremely preterm (<28 weeks)
- Very preterm (28 to <32 weeks)
- Moderate preterm (32 to <37 weeks).
- Moderate preterm birth may be further split to focus on late preterm birth (34 to <37 completed weeks).

**Low birth weight** is defined as weight at **birth of less than 2,500 grams (5.5 pounds)**. This is based on epidemiological observations that infants weighing less than 2,500 g are approximately 20 times more likely to die than heavier babies. This is further subdivided as follows:

- Very low birthweight is less than 1,500 g (up to and including 1,499 g)
- Extremely low birthweight is less than 1,000 g (up to and including 999 g).

**Preterm birth is a risk factor for low birth weight.**
Global burden of preterm deliveries

- Preterm delivery is a major risk factor for neonatal deaths, responsible for 35% of the world’s 3.1 million deaths a year, and the second most common cause of under-5 deaths only surpassed by pneumonia.

- Approximately 55% of all preterm births occur in males; boys have a disproportionately higher risk of dying when compared to girls born at a similar gestation.

- 15 million preterm births occur every year and this figure is rising.

- 1.1 million babies die from preterm birth complications.

- The range of preterm birth rates across 184 countries of the world is 5-18%.

- More than 80% of preterm births occur between 32-37 weeks’ gestation and most of these babies can survive with essential newborn care.

- More than 75% of deaths of preterm births can be prevented without intensive care.

Global burden of preterm deliveries

Click on the image to find out the 10 countries with the highest burden of preterm births as well as preterm birth rate range of your country.

Measuring preterm birth

By definition, preterm birth rate is:

All live births before 37 completed weeks (whether singleton or multiple)  
Per 100 live births.

Challenges in estimation of preterm birth rates for comparison arise mostly from the numerator because of a) variations in the definition of the term ‘preterm’; b) varying methods used to measure gestational age, and c) differences in case ascertainment and registration in different countries (both numerator and denominator).
Module 1: Background on preterm birth

World Health Organization estimates of preterm birth rates

The boundaries and names shown and the designations used on this map do not imply the expression of any opinion whatsoever on the part of the World Health Organization concerning the legal status of any country, territory, city or area or of its authorities, or concerning the delimitation of its frontiers or boundaries. Dotted lines on maps represent approximate border lines for which there may not yet be full agreement.

Data Source: World Health Organization
Map Production: Public Health Information and Geographic Information Systems (GIS) World Health Organization

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Note: rates by country are available on the accompanying wall chart.
Not applicable= non WHO Members State

World Health Organization estimates of preterm birth rates

Statistical modelling has been used to estimate preterm birth rates. For countries with available data based on good vital registration for maternal deaths, using the standard definition for preterm birth, and with data for more than 50% of the years 1990–2010, country-level loess regression to estimate preterm birth rates for all years was used.

In countries with inadequate data, due to regional variations in the quality of data available and the underlying causes and predictors of preterm birth between high-income settings and the rest of the world, two additional models have been employed for “Developed regions” and “Latin America and the Caribbean” (model I), and another to estimate the preterm birth rate in all other regions of the world (model II).

As a result, distribution of preterm birth according to gestational age subgroup based on meta-analysis may be summarised as follows:

<table>
<thead>
<tr>
<th>Preterm birth grouping</th>
<th>Gestational age</th>
<th>Proportion of all &lt;37 weeks (%)</th>
<th>Lower 95% uncertainty interval</th>
<th>Higher 95% uncertainty interval (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Extremely preterm</td>
<td>&lt;28 weeks</td>
<td>5.2%</td>
<td>5.1%</td>
<td>5.3%</td>
</tr>
<tr>
<td>Very preterm</td>
<td>28–&lt;32 weeks</td>
<td>10.4%</td>
<td>10.3%</td>
<td>10.5%</td>
</tr>
<tr>
<td>Moderate or Late</td>
<td>32–36 weeks</td>
<td>84.3%</td>
<td>84.1%</td>
<td>84.5%</td>
</tr>
</tbody>
</table>

Risk factors for preterm births

Preterm birth can either be **spontaneous** or **provider-initiated**.

**Risk factors for spontaneous preterm births include:**

- **age at pregnancy and pregnancy spacing** (e.g., adolescent pregnancy, advanced maternal age, or short interpregnancy interval);
- **multiple pregnancy** (increased rates of twin and higher order pregnancies with assisted reproduction);
- **infections** (urinary tract infections, malaria, HIV, syphilis, bacterial vaginosis);
- **pre-existing maternal chronic medical conditions** (diabetes, hypertension, anaemia, asthma, thyroid disease);
- **nutritional** (undernutrition, obesity, micronutrient deficiencies);
- **lifestyle/ work related** (smoking, excess alcohol consumption, recreational drug use, excess physical work/activity);
- **maternal psychological health** (depression, violence against women);
- **genetic and other genetic risks**, e.g., family history, cervical incompetence

**Risk factors for provider-initiated preterm birth include:**

- **medical induction**
- **cesarean birth**

Signs and symptoms of preterm labour

It is important for the reader to familiarize themselves with signs and symptoms of preterm labour, especially if labour is spontaneous.

Sudden onset of regular, painful contractions of increasing intensity before 37 completed weeks are probably more likely to represent spontaneous preterm labour than a longer period of irregular contractions.

Other symptoms include menstrual cramps, backache, pelvic pressure, vaginal discharge, urinary frequency, diarrhoea or vaginal bleeding.

The presence of vaginal bleeding increases the risk of preterm birth and this may be suggestive of intrauterine infection. Caesarean section due to abruptio placenta before 37 weeks would definitely result into preterm delivery.

Signs and symptoms of preterm labour

Cervical effacement or dilation is confirmatory of spontaneous preterm labour.

However, digital (using fingers) examination alone may be insufficient in ruling out preterm labour, since with a closed cervix, only the vaginal portion of the cervix is palpable and dilation of the internal cervical os is difficult to detect by palpation.
Signs and symptoms of preterm labour

As such, transvaginal ultrasonographic scanning (TVUSS) assessment of the cervix in spontaneous preterm labour offers additional information where the cervix is closed, as well as providing a more accurate measure of the cervical length.

A short cervix is an independent risk factor for preterm labour. However, a shortened cervical length may be due to funnelling resulting from dilation of the internal os.

A number of studies of cervical length in women with spontaneous preterm labour have been conducted. With 30–32 mm as cutoff, the sensitivity was 81–100% for predicting delivery before 36–37 gestational weeks and 88–100% for preterm birth before 34–35 weeks.

Signs and symptoms of preterm labour

Elevated white blood cell count and serum levels of C-reactive protein (CRP) may reflect infection but also labour, since CRP also rises during labour without signs of infection.

Elevated levels of fetal fibronectin (FFN) in cervico-vaginal secretions, a glycoprotein found in high concentrations in the placenta and amniotic fluid, as well as interleukin 6 (IL-6) in the amniotic fluid and in cervical secretions are also indicative of spontaneous preterm labour.
The 10:90 survival gap

Stark differences in survival of premature babies exist between low- and high-income countries. For example, over 90% of extremely preterm babies (<28 weeks’ gestation) born in low-income countries die within the first few days of life; yet less than 10% of babies of this gestation die in high-income settings, a 10:90 survival gap.

This is despite the fact that evidence-based interventions exist to reduce mortality from preterm causes. These include feeding, temperature maintenance, hygienic cord and skin care, and early detection and treatment of infections and complications including respiratory distress syndrome.
Preterm birth vs other causes of neonatal mortality

The following infographic shows how preterm birth compares with other causes of neonatal mortality. Hover the cursor over the bottom half of the slide and click on the play button to see the infographic.

Global trend in neonatal mortality rate 1953-2015

http://www.childmortality.org/index.php?r=site/map
Long term effects of preterm births

Survivors of preterm birth are also at a significant risk of adverse long-term consequences and hence loss of human potential globally. These include:

Visual impairment
- Blindness or high myopia after retinopathy of prematurity
- Increased hypermetropia and myopia

Hearing impairment
- This affects up to 5 to 10% of extremely preterm

Chronic lung disease of prematurity
- From reduced exercise tolerance to requirement for home oxygen

Long-term cardiovascular ill-health and noncommunicable disease
- Hypertension
- Reduced lung function
- Increased rates of asthma
- Growth failure in infancy
- Accelerated weight gain in adolescence

Long term effects of preterm births (cont’d)

Neurodevelopmental/ behavioral effects
Disorders of executive functioning
- Specific learning impairments, dyslexia, reduced academic achievement

Moderate to severe global developmental delay
- Moderate/severe cognitive impairment
- Motor impairment
- Cerebral palsy affected by gestational age and quality of care dependent

Psychiatric/ behavioral sequelae
- Attention deficit hyperactivity disorder
- Increased anxiety and depression

Family, economic and societal effects
- Impact on family, the health service and intergenerational effects
- Psychosocial, emotional and economic
- Cost of care – acute and ongoing
- Risk of preterm birth in offspring is common, varying with medical risk factors, disability, socioeconomic factors

Global goals in the context of preterm feeding and growth monitoring

Greater efforts are needed to minimize preterm delivery and, importantly, maximize the survival chances of those already born too soon.

Evidence-based feeding approaches together with other high impact interventions are therefore crucial. Monitoring of progress should be standardized.

Growth progress at the level of an individual preterm infant should be a continuum from conception through infancy and childhood.

The INTERGROWTH-21st growth standards allow all preterms to benefit from a postnatal growth monitoring strategy that matches the WHO Child Growth standards and provides continuity of care from the first day of postnatal life to life at home.

Global goals in the context of preterm feeding and growth monitoring

Progress at a global level can only be measured by standardization of practices and working towards set goals. *Born Too Soon* presents a new goal for the reduction of deaths due to complications of preterm birth.

- For countries with a current neonatal mortality rate level of less than 5 per 1,000 live births, the goal is to eliminate remaining preventable preterm deaths, focusing on equitable care for all and quality of care to minimize long-term impairment (March of Dimes, 2012).

Hover the cursor over the bottom half of the slide and click on the play button of the infographic to see if your country falls in this category, its baseline (2010) and 5-year progress (World Bank Group 2016).

<table>
<thead>
<tr>
<th>Country</th>
<th>2010</th>
<th>2015</th>
<th>Trend</th>
</tr>
</thead>
<tbody>
<tr>
<td>San Marino</td>
<td>1</td>
<td>1</td>
<td>-</td>
</tr>
</tbody>
</table>


Global goals in the context of preterm feeding and growth monitoring

For countries with a current neonatal mortality rate level of more than or equal to 5 per 1,000 live births, the goal is to reduce the mortality due to preterm birth by 50% between 2010 and 2025 (March of Dimes, 2012).
Global goals in the context of preterm feeding and growth monitoring

Global nutrition targets 2025
A comprehensive implementation plan on maternal, infant and young child nutrition, was endorsed by a resolution of the World Health Assembly, and identified six key areas of focus:

1. STUNTING | THE GOAL
   By 2025, reduce by 40% the number of children aged under 5 years who are stunted

2. ANAEMIA | THE GOAL
   By 2025, achieve a 50% reduction in the rate of anaemia in women of reproductive age

3. LOW BIRTH WEIGHT | THE GOAL
   By 2025, achieve a 30% reduction in low birth weight

4. OVERWEIGHT | THE GOAL
   By 2025, no increase in childhood overweight

5. BREASTFEEDING | THE GOAL
   By 2025, increase to at least 50% the rate of exclusive breastfeeding in the first six months

6. WASTING | THE GOAL
   By 2025, reduce and maintain childhood wasting to less than 5%
Gestational age assessment

Gestational age (GA) estimation is part of fetal growth monitoring. In estimating the gestational age, the most accurate “gold standard” for assessment is routine early ultrasound assessment using fetal measurements made in the first trimester (March of Dimes, 2012).

This is accomplished in clinical practice by measuring the fetal crown–rump length (CRL) or head circumference at < 14 weeks’ and ≥ 14 weeks’ gestation, respectively. This is because between 9 and 13 weeks’ gestation, linear growth evaluated by CRL is rapid and the standard deviation is rather small, which means that GA can be estimated accurately (Papageorghiou AT, 2014).

As the fetus enters the second and third trimesters, CRL is no longer useful owing to curling of the growing fetus and therefore head circumference is used in later pregnancy. However, variation is greater, which results in less accurate estimation of GA (Papageorghiou, 2014).

In the first trimester access to ultrasound may not be possible in many parts of developing countries due to delay in attending antenatal clinics, lack of skills, unavailability of equipment etc. and hence, there is reliance on other less reliable methods such as last menstrual period (LMP), birth weight, fundal height or newborn examinations(March of Dimes, 2012).

Comparisons between these approaches are elucidated in the next slide.
## Estimating gestational age

<table>
<thead>
<tr>
<th>Method</th>
<th>Accuracy</th>
<th>Details</th>
<th>Availability/feasibility</th>
<th>Limitations</th>
</tr>
</thead>
<tbody>
<tr>
<td>Early ultrasound scan</td>
<td>+/- 5 days if first trimester</td>
<td>Estimation of fetal crown-rump length +/- biparietal diameter / femur length between gestational age 6 – 18 weeks</td>
<td>Ultrasound not always available in low-income settings and rarely done in first trimester</td>
<td>May be less accurate if fetal malformation, severe growth restriction or maternal obesity</td>
</tr>
<tr>
<td>Fundal Height</td>
<td>+/- 3 weeks</td>
<td>Distance from symphysis pubis to fundus measured with a tape measure</td>
<td>Feasible and low cost</td>
<td>In some studies similar accuracy to LMP</td>
</tr>
<tr>
<td>Last menstrual period</td>
<td>+/- 14 days</td>
<td>Women’s recall of the date of the first day of her last menstrual period</td>
<td>Most widely used</td>
<td>Lower accuracy in settings with low literacy. Affected by variation in ovulation and also by breastfeeding. Digit preference</td>
</tr>
<tr>
<td>Birthweight as a surrogate of gestational age</td>
<td>More sensitive/specific at lower gestational age e.g. &lt;1500 g most babies are preterm</td>
<td>Birthweight measured for around half of the world’s births</td>
<td>Requires scales and skill. Digit preference</td>
<td></td>
</tr>
<tr>
<td>Newborn examination</td>
<td>+/- 13 days for Dubowitz, higher range for all others</td>
<td>Validated scores using external +/- or neurological examination of the newborn e.g. Parkin, Finnstrom, Ballard and Dubowitz scores</td>
<td>Mainly specialist use so far. More accurate with neurological criteria which require considerable skill. Potential wider use for simpler scoring systems</td>
<td>Accuracy dependant on complexity of score and skill of examiner. Training and ongoing quality control required to maintain accuracy</td>
</tr>
<tr>
<td>Best obstetric estimate</td>
<td>Around +/- 10 days (between ultrasound and newborn examination)</td>
<td>Uses an algorithm to estimate gestational age based on best information available</td>
<td>Commonly used in high-income settings</td>
<td>Various algorithms in use, not standardized</td>
</tr>
</tbody>
</table>

Adapted from Parker, Lawn and Stanton (unpublished Master’s thesis)

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Gestational age assessment- The INTERGROWTH-21st International Standards

Crown-Rump Length (CRL)
The INTERGROWTH-21st Project, through the Fetal Growth Longitudinal Study, a multi-center study in eight geographically diverse countries, produced the first prescriptive international standards for early fetal size and ultrasound dating of pregnancy based on CRL measurement.

As a result, GA can be estimated from measurements of CRL between 15mm and 95 mm by the two equations in which CRL is expressed in mm and GA in days:

\[
\text{GA} = 40.9041 + (3.21585 \times \text{CRL}^{0.5}) + (0.348956 \times \text{CRL});
\]
\[
\text{SD of GA} = 2.39102 + (0.0193474 \times \text{CRL}).
\]

Likewise, for GA between 58 and 105 days’ gestation, where GA is expressed in days and CRL in mm:

\[
\text{Mean CRL} = -50.6562 + (0.815118 \times \text{GA}) + (0.00535302 \times \text{GA}^2);
\]
\[
\text{SD of CRL} = -2.21626 + (0.0984894 \times \text{GA}).
\]

These standards complement the existing WHO Child Growth Standards.

Gestational age assessment- The INTERGROWTH-21st International Standards

Symphysis-Fundal Height (SFH)
In low and middle income countries, where access to ultrasound machines and trained ultrasonographers is limited, or where women may attend their first antenatal clinic after the first trimester, SFH measurement is applicable as a simple, inexpensive, first level, screening tool.

The Fetal Growth Longitudinal Study has also generated the first prescriptive international standards for measuring symphysis-fundal-height as a first level screening for intrauterine growth disturbances.

Estimation of gestational age from SFH:

GA (exact weeks) = 6.585838 − 2.7072585 \times \text{SFH}_{0.5} + 1.295291 \times \text{SFH}

International symphysis-fundal height (SFH) standards for clinical use. Lines (from bottom to top)=3rd, 10th, 50th, 90th, and 97th centiles. A printable chart is available in the supplementary appendix (can also be found at https://intergrowth21.tghn.org/ under “INTERGROWTH Standards & Tools”).

Initial assessment of the preterm infant

Anthropometric assessment
After establishing the gestational age of the preterm infant at birth, head circumference, length and weight are measured.

The equipment and technique used has been described in the module Assessing newborn size by anthropometry. The learner is encouraged to consult this module. A booklet on anthropometry can also be downloaded from the INTERGROWTH website.

The anthropometric measures are then compared to standards using INTERGROWTH-21st Postnatal Growth Standards, centiles and z-scores for Preterm Infants. Charts for head circumference, length, and weight for boys and girls are available here. Likewise, charts for very preterm babies can also be downloaded here.

An online tool, as well as installable Windows and Apple IOS applications available here allow data to be entered manually so that the size of individual newborns can be compared to, and plotted graphically against, the international references.
Initial assessment of the preterm infant

Anthropometric assessment video
Click on the play button to watch.
Initial assessment of the preterm infant

INTERGROWTH-21st Newborn Size Application Tool
This is an easy-to-use tool for calculating centiles and z-scores for weight, length and head circumference at birth. For example, a very preterm baby boy born at 26 weeks' gestation with a weight of 0.850 kg, 36cm length and 25cm head circumference would compare to standards as shown in the snapshot below. Hover the cursor over the bottom half of the slide and click on the play button to see the demo.
WHO recommendations on interventions to improve preterm birth outcomes

The World Health Organization has developed a set of recommendations designed to improve outcomes for preterm babies. While this module focuses on the newborn interventions, maternal interventions will also be considered, especially where preterm delivery is inevitable.

Newborn interventions

Kangaroo mother care (KMC) is a package that entails early, continuous and prolonged skin-to-skin contact between the mother and the baby, and exclusive breastfeeding (ideally) or feeding with breastmilk. It is recommended for the routine care of newborns weighing 2000 g or less at birth, and should be implemented as follows:

- Initiation in healthcare facilities as soon as the newborns are clinically stable. (Strong recommendation based on moderate-quality evidence)
- Provided as close to continuous as possible. (Strong recommendation based on moderate-quality evidence)
- Provided intermittently, rather than conventional care, if continuous Kangaroo mother care is not possible (Strong recommendation based on moderate-quality evidence)

WHO recommendations on interventions to improve preterm birth outcomes

Newborn interventions (cont’d)

Kangaroo mother care (KMC)
Unstable newborns weighing 2000 g or less at birth, or stable newborns weighing less than 2000 g who cannot be given Kangaroo mother care, should be cared for in a thermo-neutral environment either under radiant warmers or in incubators. (Strong recommendation based on very low-quality evidence)

There is not enough evidence in support of routine use of plastic bags/wraps for providing thermal care for preterm newborns immediately after birth. However, during stabilization and transfer of preterm newborns to specialized neonatal care wards, wrapping in plastic bags/wraps may be considered as an alternative to prevent hypothermia. (Conditional recommendation based on low-quality evidence)

Continuous positive airway pressure therapy is recommended for the treatment of preterm newborns with respiratory distress syndrome and should be started as soon as the diagnosis is made.

WHO recommendations on interventions to improve preterm birth outcomes

Newborn interventions (cont’d)

Surfactant administration

- In health-care facilities where intubation, ventilator care, blood gas analysis, newborn nursing care and monitoring are available, surfactant replacement therapy is recommended for newborns with respiratory distress syndrome. Either animal-derived or protein-containing synthetic surfactants may be used. However, surfactant should not be administered prophylactically before onset of symptoms.
- In intubated preterm newborns with respiratory distress syndrome, surfactant should be administered early (within the first 2 hours after birth) rather than waiting for the symptoms to worsen before giving rescue therapy.

Oxygen therapy

- Preterm babies born at or before 32 weeks' gestation should start oxygen therapy with 30% oxygen or air (if blended oxygen is not available), rather than with 100% oxygen. (Strong recommendation based on very low-quality evidence)
- The use of progressively higher concentrations of oxygen should only be considered for newborns undergoing oxygen therapy if their heart rate is less than 60 beats per minute after 30 seconds of adequate ventilation with 30% oxygen or air. (Strong recommendation based on very low-quality evidence)
- Oxygen concentration should be guided by blood oxygen saturation levels. However, measurement of these saturation levels should not supersede early efforts at resuscitation of the preterm newborn and hence saturation-level monitoring should be initiated 2 minutes after birth. This means that use of cues of hypoxia such as cyanosis should be emphasized.

WHO recommendations on interventions to improve preterm birth outcomes

Maternal interventions

Antenatal corticosteroids for improving newborn outcomes

- Antenatal corticosteroid therapy is recommended for women at risk of preterm birth from 24 weeks to 34 weeks’ gestation when the following conditions are met:
  
  - gestational age assessment can be accurately undertaken
  - preterm birth is considered imminent
  - there is no clinical evidence of maternal infection
  - adequate childbirth care is available (capacity to recognize and safely manage preterm labour and birth)
  - the preterm newborn can receive adequate care if needed (including resuscitation, thermal care, feeding support, infection treatment and safe oxygen use).

- For eligible women, antenatal corticosteroid should be administered when preterm birth is considered imminent within 7 days of starting treatment, including within the first 24 hours. (Strong recommendation based on low-quality evidence)

WHO recommendations on interventions to improve preterm birth outcomes

Maternal interventions (cont’d)

Antenatal corticosteroid therapy is recommended for women

- at risk of preterm birth irrespective of whether a single or multiple birth is anticipated. (Strong recommendation based on low-quality evidence)
- with preterm prelabour rupture of membranes and no clinical signs of infection. (Strong recommendation based on moderate-quality evidence for newborn outcomes and low-quality evidence for maternal outcomes)
- with hypertensive disorders in pregnancy who are at risk of imminent preterm birth.
- at risk of imminent preterm birth of a growth-restricted fetus. (Strong recommendation based on very low-quality evidence)
- with pre-gestational and gestational diabetes who are at risk of imminent preterm birth, and this should be accompanied by interventions to optimize maternal blood glucose control. (Strong recommendation based on very low-quality evidence)

WHO recommendations on interventions to improve preterm birth outcomes

Maternal interventions (cont’d)

Antenatal corticosteroid therapy is not recommended for women

- with chorioamnionitis who are likely to deliver preterm. (Conditional recommendation based on very low-quality evidence)
- undergoing planned caesarean section at late preterm gestations (34–36+6 weeks). (Conditional recommendation based on very low-quality evidence for newborn and maternal outcomes)
WHO recommendations on interventions to improve preterm birth outcomes

Maternal interventions (cont’d)

Antenatal corticosteroid therapy

● Either intramuscular (IM) dexamethasone or (IM) betamethasone (total 24 mg in divided doses) is recommended as the antenatal corticosteroid of choice when preterm birth is imminent. (Strong recommendation based on low-quality evidence)

● A single repeat course of antenatal corticosteroid is recommended if preterm birth does not occur within 7 days after the initial dose, and a subsequent clinical assessment demonstrates that there is a high risk of preterm birth in the next 7 days. (Conditional recommendation based on moderate-quality evidence for newborn outcomes and low-quality evidence for maternal outcomes)
WHO recommendations on interventions to improve preterm birth outcomes

Maternal interventions (cont’d)

Tocolysis for inhibiting preterm labour and improving newborn outcomes

- Tocolytic treatments (acute and maintenance treatments) are not recommended for women at risk of imminent preterm birth for the purpose of improving newborn outcomes. (Conditional recommendation based on very low-quality evidence)

Magnesium sulfate for fetal protection from neurological complications

- The use of magnesium sulfate is recommended for women at risk of imminent preterm birth before 32 weeks’ gestation for prevention of cerebral palsy. (Strong recommendation based on moderate-quality evidence)
WHO recommendations on interventions to improve preterm birth outcomes

Maternal interventions (cont’d)

Antibiotics for women in preterm labour (with and without prelabour rupture of membranes)

- Routine antibiotic administration is not recommended for women in preterm labour with intact amniotic membranes and no clinical signs of infection. (Strong recommendation based on moderate-quality evidence)
- Antibiotic administration is recommended for women with preterm prelabour rupture of membranes. (Strong recommendation based on moderate-quality evidence)
- Erythromycin is recommended as the antibiotic of choice for prophylaxis in women with preterm prelabour rupture of membranes (Conditional recommendation based on moderate-quality evidence)

Optimal mode of birth for women in refractory preterm labour

- Routine delivery by caesarean section for the purpose of improving preterm newborn outcomes is not recommended, regardless of cephalic or breech presentation. (Conditional recommendation based very low-quality evidence)
You have completed the module Background on preterm birth and you should now be able to:

- Define the different categories of preterm delivery and low birth weight.
- Know the global burden of preterm deliveries and calculate preterm birth rates.
- Identify the risk factors for preterm delivery.
- List the long-term effects of preterm deliveries.
- State the global goals for reduction of preterm deaths and the 2025 Global Nutrition targets.
- Know the different methods for gestational age estimation and their strengths and limitations.
- Assess gestational age from crown-rump length and symphysis-fundal height measurements using the respective INTERGROWTH-21st international standards.
- Conduct an anthropometric assessment of the newborn preterm.
- Use the INTERGROWTH-21st postnatal growth standards for preterm infants and INTERGROWTH-21st Newborn Size Application Tool.
- Know the WHO recommendations on the following interventions for preterm deliveries: Kangaroo mother care, continuous positive airway pressure, surfactant administration, oxygen therapy, antenatal corticosteroids administration, tocolysis for inhibiting preterm labour and magnesium sulfate administration.
References

- Intergrowth 21st Video. YouTube; 2016 Sep 27. Available from: https://www.youtube.com/watch?v=bWJkDmZ6qPc